DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 14, 2023

Licensee
Claddagh Senior Living
508 Kruckow Avenue North
Caledonia, MN 55921

RE: Project Number(s) SL33458015

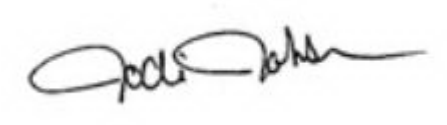
Dear Licensee:

On April 5, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 30, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
State Rapid Response Team / State Evaluation Team
Health Regulation Division
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: 651-281-9796

HHH

Electronically Delivered

February 3, 2023

Licensee
Claddagh Senior Living
508 Kruckow Avenue North
Caledonia, MN 55921

RE: Project Number(s) SL33458015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 30, 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.

LICENSING ORDERS
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 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order 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

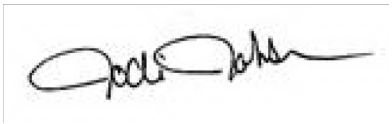
REQUESTING A HEARING

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
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#33458015 On, December 27, 2022, through December 30, 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 37 active residents; 34 receiving services under the Assisted Living Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 110	Continued From page 1 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 27, 2022, at 1:00 p.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license effective through October 31, 2022; however, LALD-A's license lacked an organization listed as the Director of Record for the licensee. On December 27, 2022, at 1:36 p.m. the evaluator emailed a BELTSS representative to clarify LALD-A's status as director of record for the facility. At 1:43 p.m., the BELTSS representative responded "She has not updated her Director of Record for any location. Those instructions have been sent out to the LALD several times over the course of the license renewals since July 2022-October 21, 2022. I did check and that location is in our database. There is no other LALD on record for this location. She should contact BELTSS, if she does not know	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 110	Continued From page 2 how to update her license portal." On December 27, 2022, at 2:15 p.m. LALD-A stated she thought she had turned everything in to BELTSS and did not recall receiving email contact from BELTSS with additional requirements. LALD-A stated she would immediately contact the representative from BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 250	Continued From page 3 access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the 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	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 250	Continued From page 4 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 December 27, 2022, at 11:00 a.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	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 250	Continued From page 5 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 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	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 250	Continued From page 6 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 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 LALD-A on May 26, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of October 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 250	Continued From page 7 implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; - supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued 0510, 0660, 1370, 1380, 1420, 1440, 1470, 1540, 1620, 1710, 1730, 1760, 1790, 1880, 1890, 1940, 1950, 1960, 1970, and 2140 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	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 470	Continued From page 8 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the 24-hour staffing schedule was posted with all required information, and a staffing plan was developed to determine staffing levels to meet the needs of all residents. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 470	Continued From page 9 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: The licensee held an assisted living dementia facility license, and at the time of the survey had a census of 37 residents. STAFFING SCHEDULE On December 27, 2022, at 10:52 a.m. the facility posted staff schedule was observed posted on a bulletin board located on a wall near the front desk in the main lobby. The posting included "A.M. staff 3 Aides, P.M. staff 3 Aides, NOC [night] staff 2 Aides, RN [registered nurse] on call 24 hrs [hours]". On December 27, 2022, at 12:40 p.m. licensed assisted living director (LALD)-A observed the posted staff schedule with the evaluator and stated the posting was the facility's "posted staff schedule". LALD-A verified the posting did not include all required content. LALD-A stated, "We can fix that." LALD-A stated, "We don't have it posted in the memory care unit [locked unit], now that you mention that." 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;	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 470	Continued From page 10 -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 STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining its staffing level that: -includes 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 -ensured that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; On December 29, 2022, at 10:20 a.m. LALD-A stated "the RN reviews and approves the schedule. We don't have a written staffing plan".	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 470	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure at least three nutritious meals daily according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines.	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 485	Continued From page 12 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: The licensee's menu provided for the dates of December 26, 2022, through January 1, 2023, lacked evidence of fruit for "lunch" meals listed and dairy to be included on the menu to meet the USDA guidelines as required. No beverages were listed on the menu. On December 30, 2022, at 10:37 a.m. housing manager (HM)-C stated she was the certified food protection manager for the facility. HM-C reviewed the menu with the evaluator and verified the information listed above. HM-C stated, "I know they serve drinks" with meals, which included milk. HM-C stated herself and the "cook make the menus". The licensee's Food Service and Menu Planning policy dated August 9, 2021, indicated the licensee would offer to provide and make available three meals daily with snacks available seven days per week according tot he recommended dietary allowances in the USDA guidelines, including seasonal fresh fruit and fresh vegetables. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during treatment and medication administration for one of four residents (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee failed to ensure gloves were worn	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 510	Continued From page 14 and proper handwashing occurred during and in between the administration of R8's nasal spray and eye drops. On December 28, 2022, at 8:45 a.m. unlicensed personnel (ULP)-F was observed to administer oral medications and then administered nasal spray to R8 without glove use and proceeded without handwashing or glove use to administer R8's eye drops. On December 28, 2022, at 10:30 a.m. RN-B stated she expected gloves to be worn with the administration of nasal medications and eye drops. She expected ULP to remove gloves in between nasal medication administration with hand washing and clean gloves donned prior to the administration of eye drops. The licensee's Gloves policy dated August 1, 2021, indicated gloves must be worn whenever there may be direct contact between and employee and contaminated objects or as instructed. The licensee's Handwashing policy dated August 1, 2022, indicated hand washing would be performed by all employees as necessary, between tasks and procedures. Additionally, when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning and after removing gloves. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 550	Continued From page 15	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information related to the grievance procedure. 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: The licensee lacked postings in a conspicuous location and a disclosure of resident advocacy to include: -the e-mail contact information for the individuals who are responsible for handling resident	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 550	Continued From page 16 grievances; and -the contact information for the regional Office of Ombudsman for Mental Health and Developmental Disabilities On December 27, 2022, at 12:40 p.m. licensed assisted living director (LALD)-A observed the facility posted grievance information with the evaluator and verified the posting did not include the required content listed above. LALD-A stated, "We can fix that." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure development of an individual abuse prevention plan with the required content for one of three residents (R1).	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 630	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's Service Plan dated September 14, 2022, indicated R1 received services to include medication administration, blood glucose checks, wound-care and daily safety checks. R1's Individual Abuse Prevention Plan (IAPP) dated September 9, 2022, indicated on page five in the section identified as "Is resident susceptible to abuse from another individual, including other vulnerable adults?" An "X" with "(no)" was entered into the column under "False". Additionally, the document lacked an approach/intervention or goal regarding R1's susceptibility to abuse by others. On December 29, 2022, at 2:30 p.m. licensed assisted living director (LALD)-A confirmed R1's IAPP lacked the indication he was susceptible to abuse by others. LALD-A stated all residents are susceptible to abuse by others. LALD-A stated she would update the information to correct it. The licensee's Vulnerable adult Maltreatment prevention and reporting policy dated August 1, 2021, indicated the licensee developed individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 630	Continued From page 18 identified information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with 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 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 all 37 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	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 640	Continued From page 19 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 December 28, 2022, at 10:19 a.m. observation of the facility with licensed assisted living director (LALD)-A identified posted 911 and MAARC information located by a phone behind the main lobby desk. No 911 emergency number or the required MAARC information was posted in common areas. LALD-A stated "yes, the only place" the information was posted in the facility building was by the phone behind the main lobby desk. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 660	Continued From page 20 volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for one of two employees (unlicensed personnel (ULP-F). 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 August 1, 2022, indicated they were a low risk. ULP-F's personnel file identified she was hired on May 17, 2021. ULP-F's personnel file included a record of her two step TST skin tests completed on May 20, 2021, and June 11, 2021, which were both negative for TB. On December 29, 2022, at 8:45	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 660	Continued From page 21 a.m. housing manager (HM)-C provided the evaluator with ULP-F's TB Screening Tool dated December 29, 2022. The personnel file had no evidence a TB symptom screening was completed, or within 90 days prior to the hire date. On December 30, 2022, at 9:00 a.m. licensed assisted living director (LALD)-A verified ULP-F's TB screening tool was completed and dated during the time of the survey. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated for staff screening, "Staff whose essential job functions require work within the same air space of 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 would be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs 2. 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. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis.	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 660	Continued From page 22 The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's Tuberculosis Screening Policy dated August 1, 2021, indicated for staff screening: Staff whose essential job functions require work within the same air space of care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed. 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	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 680	Continued From page 23 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 exit diagrams were posted on each floor. This had the potential to affect all 37 residents, 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:	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 680	Continued From page 24 EMERGENCY EXIT DIAGRAM On December 27, 2022, at 11:02 a.m. observation of the facility with licensed assisted living director (LALD)-A revealed no emergency exit diagrams were posted on the first floor of the assisted living services area (outside of the locked memory care unit on the first floor). LALD-A verified at the time and stated "we give each resident a copy" of the emergency exit diagram. The licensee's Disaster Planning and Emergency Preparedness Policy dated August 1, 2021, indicated the license would post emergency diagrams on each floor, of the facility, and had a written policy and procedure regarding missing residents. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=E	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	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 730	Continued From page 25 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 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 observation, interview, and record review, the licensee's registered nurse (RN) failed to ensure documentation of weekly wound condition and measurements for one of one	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 730	Continued From page 26	0 730		

residents (R1); failed to document the services provided for one of three residents (R3) and failed to ensure the resident record included a discharge summary with the required content and provided information to the receiving facility as required for two of two discharged residents (R4, R5).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R1
R1's record lacked evidence of weekly nurse notes with wound description and wound measurements for R1's stage four coccyx wound (a wound at the base of the tailbone, with an opening that extends through the skin tissue, muscle, to the bone.)

R1's diagnoses included diabetes mellitus, stage four sacral pressure injury with history of osteomyelitis (an infection/inflammation in the bone), benign prostatic hyperplasia with lower urinary tract symptoms (enlarge prostate resulting in recurrent urinary tract infections, and giant cell arthritis (inflammation of the lining of the arteries, often affecting arteries in the head which can result in blindness).

R1's Service Plan Addendum dated September

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 730	Continued From page 27 14, 2022, indicated R1 received services to include medication administration, blood glucose checks, wound- care and daily safety checks. On December 28, 2022, at 8:15 a.m. unlicensed personnel (ULP)-F was observed to assist R1 with medication administration, blood glucose check, and wound care. The evaluator observed ULP-F complete wound care with the following steps as directed on R1's wound care instructions dated November 8, 2022, which read, "AM and PM shift to complete, 1. Continue with dressing changes twice daily. 2. Gently remove old dressing. 3. Use 2 x 2 inch gauze opened up and moistened with Anasept wound cleaner-Then will switch back to Dakins solution [cleansing solution] once it runs out. [ULP-F used Dakins solution], 4. Apply petroleum around wound 5. Cover with ABD pad [large rectangular shaped absorbent dressing] and affix with medipore tape [a gentle medical grade tape]. R1's Care Tracking Sheet dated December 2022, indicated ULP were providing wound care twice daily. R1's Wound care documentation record dated November 29, 2022-December 1, 2022, included the times of 9:00 a.m. and 5:00 p.m. as the designated times for R1's dressing changes. The ULP documented information for the following characteristics of the wound: drainage amount, drainage color, wound bed color, signs of infection, and peri area (other areas in the groin) skin integrity. R1's record included the following Wound Clinic visit notes: -April 15, 2022, indicated wound location of "coccyxgeal" [base of tailbone], wound exudate	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 730	Continued From page 28 [drainage] moderate, wound measurements 4.2 cm [centimeters] long x [by] 1.2 cm wide x 3.7 cm deep. -May 25, 2022, read "Wound care orders-Twice daily wet to dry with dakins and 2 [two] inch kerlix gauze. Pack while patient in lying down flat on stomach. Make sure packing is all the way in the wound. Cover with gauze and ABD as you have been doing." -June 23, 2022, read "Right side of wound silver nitrated [a chemical used to treat various skin concerns and enhance wound healing]. Continue with current wound cares. Wound center- 2 weeks, nurse only." -July 9, 2022, read "Wound now probes to bone. Pt [patient] will get x-ray at his convenience and discuss next steps with [provider's name] at next appointment. Continue same treatment. Make sure packing reaches base of the wound. Packing should completely fill the space but not so it's tight. Fluff, don't stuff." -November 7, 2022, read "Wound clinic visit-wound clean but deeper. Continue BID [twice daily] dressings- use 2 x 2 [inch] gauze opened up and moistened with Anasept wound cleanser, petroleum to periwound [wound on buttock area] ABD, paper tape. Discontinue Dakins 0.125% , F/U [follow up] 6 [six] weeks." R1's Nurse's Notes dated July 15, 2022, through December 9, 2022, included the following entries related to his coccyx wound: -July 30, 2022, read "Wound care continues, His [R1] wound looks good on outside, but is told in wound clinic that it's tracking inside. The opening is getting smaller." -August 28, 2022, read "R1 wound on inside looks [written text is illegible], no extra drainage noted. Wound clinic notified. They are closed for the day."	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 730	Continued From page 29 -August 29, 2022, read "Wound clinic RN called back and stated his [R1] wound can change color due to Covid. His wound today looks darker with increased bloody drainage. No odor noted, and he does not have a fever. This writer placed a call to wound clinic and gave an update." -November 7, 2022, read "seen in wound clinic today. Dressing changes noted and supplies ordered." On December 29, 2022, at 2:30 p.m. registered nurse (RN)-B stated she saw the wound "all the time when I was there and do the dressing, I see at least weekly, and for a while the LPN [licensed practical nurse] and I were doing [the dressing change]. Ok, need to write my [nurse's] notes better, I see I'm missing documentation of these visits." R3 R3's record lacked documentation of providing the services of grooming, positioning, bed mobility, assist with orientating to person, place, time, meals and socialization/group and individual. R3's Service Plan Addendum dated August 4, 2022, indicated R3 received services including assessments, dressing, bathing, transfers, wheeling, continence assist with toileting, medication administration, treatments "add to Med [medication]/Tx [treatment]/There [therapy] plan", behavior monitoring or intervention, housekeeping and linens, personal laundry, spot/safety checks, oral care, activities escort, nail care assistance and safety assistance call pendant. On December 27, 2022, at 3:00 p.m. ULP-D stated staff dressed R3, toilet R3 every three hours with change of incontinent product, staff	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 730	Continued From page 30 used an EZ stand (mechanical lift) to transfer R3, R3 could brush her own teeth with assist to set up and reminder and staff comb R3's hair. R3's Care Tracking Sheet dated December 2022, identified staff were signing for providing the services of activities escort, ambulation/transfer full assist, bathing full assist, behavior intervention, dressing full assist, housekeeping, laundry, medication assist, nail care assist, oral care assist, CPAP assist, safety assistance, toileting assistance and whereabouts check. R3's record lacked documented evidence of staff signatures for providing the services of assistance with grooming-assist with hair care, positioning, bed mobility, orientation-assist with orientating to person, place, time, meals and socialization/group and individual. On December 29, 2022, at 12:30 p.m., LALD-A and RN-B verified staff were providing the services of assistance with grooming-assist with hair care, positioning, bed mobility, orientation-assist with orientating to person, place, time, meals and socialization/group and individual to R3. LALD-A and RN-B reviewed R3's service plan dated August 4, 2022, and verified R3's service plan lacked services of grooming-assist with hair care, positioning, bed mobility, orientation-assist with orientating to person, place, time, meals and socialization/group and individual. LALD-A and RN-B verified R3's record lacked evidence of documentation by staff for providing the services. R4 R4 began receiving services on May 14, 2022, and was discharged on November 25, 2022. R4's diagnoses included congestive heart failure.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 730	Continued From page 31 R4's progress note dated September 20, 2022, indicated we addressed R4's wish to move to another facility with social worker. Gave social worker (at hospital) information of other facilities. R4's progress note dated November 22, 2022, indicated "discharge summary". Notified by social worker (at hospital) that another facility has been found for R4. Report given to person who called from the facility. All questions answered to best of ability. R4 has been discharged from this facility. R4's undated, Discharge Summary included the following: resident's name; date of birth; physician name and phone number; allergies; diagnoses; admission information including: start of care date: Discharge information including: reason for discharge (moved to another facility); discharged to (name and city); condition upon discharge: was at hospital for past two months. In addition, R5's Discharge Summary included Record of the Inventory and Destruction of Controlled and Uncontrolled substances for medications dated December 6, 2022. R4's record lacked a discharge summary to include: - course of illness; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status In addition, R4's record lacked documented evidence of providing the following information in writing to the receiving facility to include:	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 730	Continued From page 32 - the name and address of the facility and the name and address of a person at the facility to contact for additional information; - names and addresses of any significant social or community contacts the resident has identified to the facility; - the resident's most recent service or care plan, if the resident has received services from the facility; and - the resident's current "do not resuscitate" order and "physician order for life-sustaining treatment," if any. R5 R5 began receiving services on July 27, 2021, and was discharged on August 4, 2022. R5's diagnoses included intestinal obstruction. R5's progress note dated July 29, 2022, indicated R5's family member was in agreement to R5 needing nursing home placement due to the cares R5 needed everyday. "We will assist with pursuing placement." R5's progress note dated August 4, 2022, indicated "discharge summary". Family voluntary moved R5 to the nursing home due to R5's current needs. R5 was transported by ambulance. Hospice will follow R5 to the nursing home. D/C (discharge) summary sent to (nursing home name) nursing. Spoke to social services. Report given. She can call with any further questions. R5's undated, Discharge Summary included the following: resident name; date of birth; physician name and phone number; allergies; diagnoses; admission information including: start of care date: reason for initiation of services; responsible party; services received: ADL support, behavior	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 730	Continued From page 33 management, medication management services, other: spot checks; Discharge information including: reason for discharge (moved to another facility, move to higher level of care); discharged to (name, address, phone number); condition upon discharge: stable and alert; notes: report given to social worker at nursing home. In addition, R5's Discharge Summary included Record of the Inventory and Destruction of Controlled and Uncontrolled substances for medications dated August 5, 2022. R5's record lacked a discharge summary to include: - course of illness; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status In addition, R5's record lacked documented evidence of providing the following information in writing to the receiving facility to include: - the name and address of the facility and the name and address of a person at the facility to contact for additional information; - the resident's most recent service or care plan, if the resident has received services from the facility; and - the resident's current "do not resuscitate" order and "physician order for life-sustaining treatment," if any. On December 29, 2022, at 12:30 p.m., LALD-A and RN-B verified R4 and R5's records lacked the information listed above.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 730	Continued From page 34 The licensee's Resident Record Information and Content policy dated August 1, 2021, indicated the licensee would maintain appropriate and accurate records for each resident that was receiving assisted living services, including documentation that services have been provided as identified in the service plan; documentation of significant changes in the residents status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional and all records or communications pertinent to the resident's services and a discharge summary, including service termination notice and related documentation, when applicable. The licensee's Contract Termination policy dated July 27, 2022, indicated "Step 7. Resident discharge summary" at the time of discharge the licensee would provide the resident, and, with the resident's consent, the resident's representatives and case manager, with a written discharge summary that included the required content as per assisted living facilities Minnesota Rules 4659.0120 Subp. 8 and Subp. 9. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 810	Continued From page 35 (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, and staff interview, the facility failed have detailed fire safety and evacuation plans and associated confirming documentation. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 810	Continued From page 36 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed that no documentation was presented during documentation review to confirm that residents that are capable of assisting in their own evacuation are being trained on the proper actions at least once a year. MD-C verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 970	Continued From page 37 property of a resident. This had the potential to affect all 37 residents. 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 included: The licensee had an assisted living license with a renewal date of August 1, 2022. R1's Assisted Living Contract was signed November 22, 2021. R2's Assisted Living Contract was signed September 1, 2021. R3's Assisted Living Contract was signed September 6, 2021. The Assisted Living Contract included the following: -Page 13, number 23. Indemnification-As an occupant of [licensee name], Resident assumes the risk for Resident's own safety and for the safety of Resident's guests and agents. Resident will indemnify and hold harmless Provider, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of Resident or Resident's guests or agents.	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
0 970	Continued From page 38 -Page 13, number 25. Liability-Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment or on Provider's premises unless such injury, death or property damage occurs as the result of Provider's own negligent acts or omissions, or those of its employees, officers, managers, owners or agents. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment or on Provider's premises. On December 29, 2022, at 12:30 p.m. licensed assistant living director (LALD)-A stated the licensee's lawyer worked closely with a state advocacy agency. LALD-A stated she was not aware this part of the contract was prohibited and stated she would contact the lawyer to let them know. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01060	Continued From page 39 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01060	Continued From page 40	01060		

required content for an emergency relocation for four of four residents (R1, R2, R3, R4) and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for three of four residents (R1, R2, R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

R1
R1 was admitted to assisted living services on November 23, 2021.

R1's Service Plan dated September 14, 2022, indicated R1 received services to include medication administration, blood glucose checks, wound-care and daily safety checks.

R1's progress note dated September 8, 2022, indicated the licensee sent R1 to urgent care and then to the hospital due to concerns with blood in urine and R1 complaints of burning with urination. R1 was hospitalized with a urinary tract infection and discharged back to the facility on September 12, 2022 (four days later).

R2
R2 was admitted to assisted living services on August 12, 2021.

R2's Service Plan Addendum dated August 22, 2022, indicated he received services to include

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01060	Continued From page 41 dressing, bathing, toileting assistance, medication management, blood glucose checks, catheter assistance, insulin injections and bowel tracking. R2's progress notes dated August 29, 2022, indicated the licensee sent R2 to the hospital via ambulance due to catheter discomfort, low blood pressure and vomiting. R2 was hospitalized for a urinary tract infection and returned to the facility on September 6, 2022 (eight days). R1 and R2's records lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1 and R2's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. R3 R3 was admitted to assisted living services on June 7, 2021.	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01060	Continued From page 42 R3's Service Plan Addendum dated August 4, 2022, indicated R3 received services including assessments, dressing, bathing, transfers, wheeling, continence assist with toileting, medication administration, treatments, behavior monitoring or intervention, housekeeping and linens, personal laundry, spot/safety checks, oral care, activities escort, nail care assistance and safety assistance call pendant. R3's record identified the following: -Notes dated March 3, 2022, R3 will be discharged from the hospital today and be returning. She has had a couple of medication changes and will start having occupational/physical therapy. -Discharge Summary hospital dated March 3, 2022, indicated stable for discharge and diagnoses recurrent falls. Date of admission was March 2, 2022; Date of discharge March 3, 2022 (overnight stay). -Discharge Summary hospital print date July 25, 2022, indicated date of admission was July 22, 2022 (three days). R4 R4 began receiving services on May 14, 2022, and was discharged on November 25, 2022. R4's diagnoses included congestive heart failure. R4's Service Plan dated June 23, 2022, indicated R4 received services including dressing, bathing, positioning and bed mobility, transfers, continence-assist with toileting, incontinence, cleansing and perineal area, medication administration, pharmacy coordination to fill and deliver meds, behavior monitoring or intervention, congregate meal, housekeeping and linens, personal laundry, transportation arrangement, socialization, daily 'I'm ok' checks, routine	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01060	Continued From page 43 delegated RN on call 24/7 and reminder for activities. R4's progress note dated September 20, 2022, indicated we addressed R4's wish to move to another facility with social worker. Gave social worker (at hospital) information of other facilities. R4's progress note dated November 22, 2022, indicated "discharge summary". Notified by social worker (at hospital) that another facility has been found for R4. Report given to person who called from the facility. All questions answered to best of ability. R4 has been discharged from this facility. R4's undated, Discharge Summary included condition upon discharge: "was at [name] hospital for past two months." R3 and R4's records lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R4's record lacked notification to the Office of Ombudsman for Long-Term Care the	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01060	Continued From page 44 resident had been relocated and had not returned to the facility within four days. On December 29, 2022, at 2:30 p.m. licensed assisted living director (LALD)-A stated the licensee had not been providing a notice with the required above content and had not been notifying the Office of Ombudsman for Long-Term Care, but would start this practice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them;	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01370	Continued From page 45 (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations for the required topics for two of two unlicensed personnel (ULP-F, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01370	Continued From page 46 ULP-F had a hire date of May 17, 2021 and provided direct care services under the licensee's assisted living with dementia care license. On December 28, 2022, at 8:15 a.m. ULP-F was observed to assist R1 with medication administration, blood glucose check, and wound care. ULP-F's record lacked evidence of training prior to providing services for the following: -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -medication, exercise, and treatment reminders; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices The following topics identified evidence of demonstrated competency but lacked evidence of training completed prior to providing services: -appropriate and safe techniques in personal hygiene and grooming, including: care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; and -standby assistance techniques and how to perform them. During interview on December 30, 2022, at 9:30	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01370	Continued From page 47 a.m. licensed assisted living director (LALD)-A stated, "we have adjusted the Educare system to reflect what is required with an auto-enrollment. I don't understand how these were not captured in Educare prior to the dates listed here, there must be a glitch in the system." Review of Educare training print out indicated training topics still missing and late dates of completion, LALD stated, "yes, it needs to be done." ULP-D ULP-D had a hire date of August 31, 2022, and provided direct care services to the licensee residents. On December 28, 2022, at 8:14 a.m. ULP-D was observed to administer medications to R3. ULP-D's record lacked documentation of completed training for the following: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01370	Continued From page 48 dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -understanding appropriate boundaries between staff and residents and the resident's family; -awareness of commonly used health technology equipment and assistive devices. ULP-D's record lacked documentation of completed competency for the following: -standby assistance techniques and how to perform them ULP-D's record included a Relias Transcript (online computer training) for training topics obtained from a prior employer; however on December 28, 2022, at 10:38 a.m. housing manager (HM)-C stated she had "no information for the content" of the topics for the "Relias training". HM-C stated, "We don't use Relias training here", so she would not know what content was covered under the topics of Relias training. On December 30, 2022, at 9:28 a.m. LALD-A and RN-B reviewed ULP-D's record and verified ULP-D's record lacked documented evidence of training and demonstrated competency evaluation for the above. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, read a registered nurse or licensed health professional may delegate tasks only to staff who are competent and possess the knowledge and skill consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. When the registered nurse or licensed health professional delegates tasks to ULP, that person will ensure that prior to the delegation the ULP is	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01370	Continued From page 49 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. The licensee's General Employee Orientation policy dated August, 14, 2021, indicated "Upon hire and prior to performing any functions of their position, each new employee and volunteer will be oriented in accordance with State and Federal regulation, as well as company policy and procedure. An orientation checklist will be completed by the employee and trainer, signed by each person, and will be filed in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01380	Continued From page 50 (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure competency training and evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-D, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F had a hire date of May 17, 2021, and provided direct care services under the licensee's assisted living with dementia care license. On December 28, 2022, at 8:15 a.m. ULP-F was observed to assist R1 with medication administration, blood glucose check, and wound care. Review of ULP-F training record "My transcript" for Educare training program and Educare competency training documents indicated ULP-F completed the following competencies, but lacked the Educare module training requirements prior to providing services:	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01380	Continued From page 51 - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. ULP-F's training record lacked the following required training topics prior to providing services: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. On December 30, 2022, at 9:30 a.m. licensed assisted living director (LALD)-A stated, "we have adjusted the Educare system to reflect what is required with an auto-enrollment. I don't understand how these were not captured in Educare prior to the dates listed here, there must be a glitch in the system." Review of Educare training print out indicated training topics still missing and late dates of completion, LALD stated, "yes, it needs to be done." ULP-D ULP-D had a hire date of August 31, 2022, and provided direct care services to the licensee's residents. On December 28, 2022, at 8:14 a.m. ULP-D was observed to administer medications to R3. ULP-D's record lacked documentation of completed training for the following: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident;	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01380	Continued From page 52 -recognizing physical, emotional, cognitive, and developmental needs of the resident; -ambulation; and -range of motioning and positioning ULP-D's record lacked documentation of completed competency for the following: -ambulation; -range of motioning; and -CPAP ULP-D's record included a Relias Transcript (online computer training) for training topics obtained from a prior employer; however, on December 28, 2022, at 10:38 a.m. housing manager (HM)-C stated she had "no information for the content" of the topics for the "Relias training". HM-C stated, "We don't use Relias training here", so she would not know what content was covered under the topics of the Relias training. On December 30, 2022, at 9:28 a.m. LALD-A and RN-B reviewed ULP-D's record and verified ULP-D's record lacked documented evidence of training and demonstrated competency evaluation for the above. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, read a registered nurse or licensed health professional may delegate tasks only to staff who are competent and possess the knowledge and skill consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. When the registered nurse or licensed health professional delegates tasks to ULP, that person will ensure that prior to the delegation the ULP is trained in the proper methods to perform the tasks or procedures for each resident and is able	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01380	Continued From page 53 to demonstrate the ability to competently follow the procedures and perform the tasks. The licensee's General Employee Orientation policy dated August, 14, 2021, indicated "Upon hire and prior to performing any functions of their position, each new employee and volunteer will be oriented in accordance with State and Federal regulation, as well as company policy and procedure. An orientation checklist will be completed by the employee and trainer, signed by each person, and will be filed in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
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.	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01420	Continued From page 54 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for two of two unlicensed personnel (ULP-F, ULP-D) who performed delegated tasks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F ULP-F had a hire date of May 17, 2021, and provided direct care services under the licensee's assisted living with dementia care license. ULP-F's record included Skill Competency Client Mobility Lifting and Safe Transfers dated May 19, 2021, which lacked an indication of "pass" or "fail" for "transfer using a Hoyer lift from bed" and the steps included the following: 1. Caregiver should move slowly. 2. Inform client of movements prior to them being initiated. 3. Caregiver assists client with bending client's knees and placing their feet on the bed. 4. Caregiver rolls client to the side. 5. Caregiver places half open sling under clients back. 6. Caregiver rolls client to the opposite side and	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01420	Continued From page 55 pulls sling through so it is lying flat on the bed. 7. Caregiver rolls client back. ULP-F's record lacked any further documented evidence for training and demonstrated competency evaluation for Hoyer lift, including transferring a resident for surface to surface (how to attach the sling straps to the Hoyer, how to operate the Hoyer for transferring from bed to wheelchair/chair, transferring from wheelchair/chair to bed). Additionally, ULP-F's record lacked documented evidence of training and demonstrated competency evaluation with the use of the Broda chair (a specialized wheelchair) and EZ stand (lift equipment used to transfer a resident while in a standing position). On December 20, 2022, at 9:50 a.m. licensed assisted living director (LALD)-A stated the above named equipment was used by ULP within the facility and the training should have been in there (ULP training file) and verified it was not in ULP-F's personnel file. ULP-D ULP-D had a hire date of August 31, 2022, and provided direct care to the licensee residents. On December 27, 2022, at 3:00 p.m. ULP-D stated staff used an EZ stand to transfer R3. On December 28, 2022, at 8:14 a.m. ULP-D was observed to administer medications to R3 who was seated in a Broda chair. ULP-D's record included Skill Competency Client Mobility Lifting and Safe Transfers dated October	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01420	Continued From page 56 6, 2022, which indicated "pass" for "transfer using a Hoyer lift from bed" and the steps included the following: 1. Caregiver should move slowly. 2. Inform client of movements prior to them being initiated. 3. Caregiver assists client with bending client's knees and placing their feet on the bed. 4. Caregiver rolls client to the side. 5. Caregiver places half open sling under clients back. 6. Caregiver rolls client to the opposite side and pulls sling through so it is lying flat on the bed. 7. Caregiver rolls client back. ULP-D's record lacked any further documented evidence for training and demonstrated competency evaluation for Hoyer lift, including transferring a resident for surface to surface (how to attach the sling straps to the Hoyer, how to operate the Hoyer for transferring from bed to wheelchair/chair, transferring from wheelchair/chair to bed). ULP-D's record lacked evidence of training and demonstrated competency evaluation for BRODA chair and EZ stand lift and Hoyer lift. On December 30, 2022, at 9:28 a.m. LALD-A and RN-B stated the licensee utilized the use of EZ stand and Hoyer lifts. LALD-A and RN-B reviewed ULP-D's record and verified ULP-D's record lacked documented evidence of training and demonstrated competency evaluation for BRODA chair, EZ stand lift and Hoyer lift. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, read a registered nurse or licensed health professional may delegate tasks only to staff who are	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01420	Continued From page 57 competent and possess the knowledge and skill consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. When the registered nurse or licensed health professional delegates tasks to ULP, that person will ensure that prior to the delegation the ULP 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01440	Continued From page 58 thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for two of two unlicensed personnel (ULP-F, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F ULP-F had a hire date of May 17, 2021, and provided direct care services under the licensee's assisted living with dementia care license. On December 28, 2022, at 8:15 a.m. (ULP)-F was observed to assist R1 with medication administration, blood glucose check, and wound care. ULP-F's personnel record lacked evidence ULP-F was supervised within 30 days of performing delegated tasks.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01440	Continued From page 59 On December 30, 2022, at 10:08 a.m. RN-B stated she had completed the supervision but likely did not document it. Licensed assisted living director (LALD)-A stated "It should have been on file, the person in charge of employee files did not maintain, and it doesn't look like it is in the file, no." ULP-D ULP-D had a hire date of August 31, 2022, and provided direct care to the licensee's residents. On December 28, 2022, at 8:14 a.m. ULP-D was observed to administer medications to R3. ULP-D's personnel record lacked evidence ULP-D was supervised within 30 days of performing delegated tasks. On December 30, 2022, at 9:28 a.m. RN-B reviewed ULP-D's record and stated "Okay. We do check in, probably not documented". The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated Staff who provide delegated nursing or therapy tasks to residents at [licensee name] will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability perform the tasks. Supervision will include observation of the staff administering the medication or treatment and the interaction with resident. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee name] and first performs the delegated tasks for residents	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01440	Continued From page 60 and thereafter as needed based on performance. Documentation of supervision activities will be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01470	Continued From page 61 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two unlicensed personnel (ULP-F and ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01470	Continued From page 62 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-F ULP-F had a hire date of May 17, 2021. On December 28, 2022, at 8:05 a.m. ULP-F was observed to administer medications, check a blood glucose and complete wound cares for R1. ULP-F's record lacked documented evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services. On December 30, 2022, at 8:50 a.m. with review of the record, licensed assisted living director (LALD)-A stated, "That's strange, someone else is overseeing, I'm not sure why this is not done." LALD-A then provided another training document named "General Orientation Checklist for New Employees;" however, this document lacked the	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01470	Continued From page 63 required training content. ULP-D ULP-D had a hire date of August 31, 2022, and provided direct care to the licensee residents. On December 28, 2022, at 8:14 a.m. ULP-D was observed to administer medications to R3. ULP-D's record lacked documented evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: -an overview of this chapter; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On December 30, 2022, at 9:28 a.m. LALD-A and RN-B reviewed ULP-D's record and verified ULP-D lacked the above orientation training. LALD-A stated, "It looks like the wrong list" was clicked on for "Educare" program (online training) for "auto enrollment". The licensee's Employee General Orientation policy dated August 14, 2021, indicated upon hire	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01470	Continued From page 64 and prior to performing any functions of their position, each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure. Additionally, employees should not perform job duties before the completion of orientation to the job including general and safety orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01540	Continued From page 65 review, the licensee failed to ensure direct care staff completed all of the the required topics for dementia training and the required amount of dementia care training in the required time frame for one of two employees (unlicensed personnel (ULP)-D). 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). ULP-D ULP-D had a hire date of August 31, 2022, and provided direct care to the licensee residents. On December 28, 2022, at 8:14 a.m. ULP-D was observed to administer medications to R3. ULP-D's record included My Transcript for Educare training (on line training program) which identified a total of seven hours of dementia training topics "completed" on the dates of September 3, 15, 16, 2022, and November 29, 2022, and Relias Transcript training (on line training program) which identified a total of 0.50 hours of dementia training topics "completed" on the date of December 26, 2021. ULP-D's record lacked documented evidence of required training for required topics of person centered planning and service delivery and evidence a total of eight hours of training was completed within 80 hours of employment start date.	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01540	Continued From page 66 On December 30, 2022, at 9:28 a.m. LALD-A and RN-B reviewed ULP-D's record and verified ULP-D lacked the above for dementia care training. LALD-A stated, "Okay". The licensee's Employee General Orientation policy dated August 14, 2021, indicated upon hire and prior to performing any functions of their position each new employee would be orientated in accordance with State and Federal Regulations, as well as company policy and procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=G	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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 67 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) had completed and/or documented a comprehensive assessment for change in condition (wounds, emergency room (ER) visits, readmission following hospitalization, fall) for three of three residents (R1, R2, R3) and failed to ensure the RN documented comprehensive monitoring and review reassessment for 90 days as required for for three of three residents (R1, R2, R3). 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 R1 had diagnoses to include diabetes mellitus, stage four sacral pressure injury with history of osteomyelitis (an infection/inflammation in the bone), benign prostatic hyperplasia with lower urinary tract symptoms (enlarge prostate resulting	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 68 in recurrent urinary tract infections, and giant cell arteritis (inflammation of the lining of the arteries, often affecting arteries in the head which can result in blindness). R1's Service Plan addendum dated September 14, 2022, indicated R1 received services to include medication administration, blood glucose checks, wound- care and daily safety checks. ASSESSMENT OF WOUND R1's record lacked documented evidence of comprehensive assessment of coccyx pressure ulcer wound of coccyx (at the base of the tailbone), including consistent weekly assessment to include size, appearance, odor, drainage and pain. R1's Care Tracking Sheet dated December 2022, indicated ULP were providing wound care twice daily. R1's Wound care documentation record dated November 29, 2022-December 1, 2022, included the times of 9:00 a.m. and 5:00 p.m. as the designated times for R1's dressing changes. The ULP documented information for the following characteristics of the wound: drainage amount, drainage color, wound bed color, signs of infection, and peri area (other areas in the groin) skin integrity. R1's record included the following Wound Clinic visit notes: -April 15, 2022, indicated wound location of "coccyxgeal" [base of tailbone], wound exudate [drainage] moderate, wound measurements 4.2 cm [centimeters] long x [by] 1.2 cm wide x 3.7 cm deep. -May 25, 2022, read "Wound care orders-Twice	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 69	01620		

daily wet to dry with dakins and 2 [two] inch kerlix gauze. Pack while patient in lying down flat on stomach. Make sure packing is all the way in the wound. Cover with gauze and ABD (abdominal pad bandage used to manage massively draining wounds) as you have been doing."
-June 23, 2022, read "Right side of wound silver nitrate [a chemical used to treat various skin concerns and enhance wound healing]. Continue with current wound cares. Wound center- 2 weeks, nurse only."
-July 9, 2022, read "Wound now probes to bone. Pt [patient] will get x-ray at his convenience and discuss next steps with [provider's name] at next appointment. Continue same treatment. Make sure packing reaches base of the wound. Packing should completely fill the space but not so it's tight. Fluff, don't stuff."
-November 7, 2022, read "Wound clinic visit- wound clean but deeper. Continue BID [twice daily] dressings- use 2 x 2 [inch] gauze opened up and moistened with Anasept wound cleanser, petroleum to periwound [wound on buttock area] ABD, paper tape. Discontinue Dakins 0.125% , F/U [follow up] 6 [six] weeks."

R1's Nurse's Notes dated July 15, 2022, through December 9, 2022, included the following entries related to his coccyx wound:
-July 30, 2022, read "Wound care continues, His [R1] wound looks good on outside, but is told in wound clinic that it's tracking inside. The opening is getting smaller."
-August 28, 2022, read "[R1] wound on inside looks [written text is illegible], no extra drainage noted. Wound clinic notified. They are closed for the day."
-August 29, 2022, read "Wound clinic RN called back and stated his [R1] wound can change color due to Covid. His wound today looks darker with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 70 increased bloody drainage. No odor noted, and he does not have a fever. This writer placed a call to wound clinic and gave an update." -November 7, 2022, read "seen in wound clinic today. Dressing changes noted and supplies ordered." There was no evidence of routine wound assessments to include measurements noted in R1's record. 90 DAY ASSESSMENTS R1's 90 day assessments lacked required content for comprehensive monitoring and review, and lacked documented physical assessment of the resident at time of review. R1's record included the following assessments: -dated June 3, 2022, Client Monitoring Visit Notes -dated June 27, 2022, Client Monitoring Visit Notes, with comment "Adjustment for insulin administration dosage." -dated August 25, 2022, Client Monitoring Visit Notes, with comment, "[R1] positive for COVID 19, no other services needed at this time." -dated September 12, 2022, [licensee name] Master Assessment, Change of Condition Assessment -post hospitalization. -dated December 9, 2022, Client Monitoring Visit Notes, with comment, "[R1] states he's feeling improved from his hospitalization." The above Client Monitoring Visit Notes sheet indicated "documentation for client must be completed no more than 90 days from the previous visit" and included "services reviewed" for housekeeping, personal hygiene, dressing, bathing, med reminders, med administration and other topics; are all home care services being performed adequately; nursing assessment	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 71 revised; care plan/services appropriate for the clients needs; are the services appropriate to the clients needs; client/family problem, concerns, or comments; unlicensed staff present; family member present. Documentation by RN-B on the sheets identified "N" (no) was circled for response to nursing assessment was revised. The sheets lacked documented evidence of physical assessment of R1 by RN-B and comprehensive review of all required content. CHANGE IN CONDITION ASSESSMENTS R1's record lacked an RN comprehensive assessment with a change in condition and lacked the required content with a Change in Condition Assessment. R1's record included nurses notes with the following entries: -August 23, 2022, entry read, [R1] states to this writer, "I'm not feeling good. He feels like a cold is coming on and his energy level is down. Temp 36.9 C. [Celsius], blood pressure (B/P)-145/79, heart rate (HR)-95, respiratory rate (RR)-20, oxygen (O2) saturations- 92% on room air (RA). Breath sounds are clear, He complains of a dry cough, His checked for Covid 19 and results are negative. Report has been called to his provider. -August 25, 2022, entry read "Still not feeling well. Another COVID test performed and he is now showing that he's positive for COVID-19. He states he has a cold. O2 sats 96%, no temp, vitals stable. He states "I feel okay, just no energy." Called report to provider. Awaiting to hear back. -September 8, 2022, read [R1] is complaining of blood in his urine and burning with urination. After eating breakfast this morning he had an emesis [vomited]. Afebrile 37.6 degrees C, HR-94 and regular. B/P-141/74, RR-20, O2 saturation levels	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 72 93%. Sent him out to urgent care for evaluation. His family is called. His sister [name] will escort him to urgent care. Then entry read at 19:00 (7:00 p.m.), [R1] is hospitalized for a UTI (Urinary tract infection). R1's hospital discharge summary dated September 12, 2022, read "Hospital course: Patient admitted with sepsis due to UTI. Cultures returned growing E.Coli (bacteria found in the bowel). CT (computerized tomography-Xray images taken at different angles around the body and uses a computer to process cross sectional images), showing emphysematous cystitis [a rare form of urinary tract infection, with the characteristic of gas within the bladder and lumen (bladder wall). Treated with IV (intravenous) ceftriaxone and transitioned to oral cefdinir to compete 7 day course. Of note, recently started jardiance (diabetes injection), and favor d/c (discontinuation), of jardiance given increased risk of UTI, trulicity recently discontinued prior due to nausea/vomiting. Likely will need titration of medications but acutely d/c. Follow-up with PCP (primary care provider) to monitor glucose control with medication adjustments." R1's Client Monitoring Visit Notes dated August 25, 2022, with comment, "[R1] positive for COVID 19, no other services needed at this time." The licensee's RN failed to complete a comprehensive nursing assessment for a change in condition for R1's COVID infection. R1's Change of Condition Assessment dated September 12, 2022, was completed by RN-B upon his discharge from the hospital; however, the assessment lacked documented review of required content for the following: B. activities of daily living, including:	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 73 (1) toileting pattern D. physical health status, including: (2) allergies and sensitivities related to medication, seasonality, and environment and if any of the allergies or sensitivities are life threatening; (3) infectious conditions; (4) a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (a) the reason taken; (b) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; (c) the dosage; (d) the frequency of use; (e) the route administered or taken; (f) any difficulties the resident faces in taking the medication; (i) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and (j) provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; (6) a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; (7) weight; M. risk indicators, including: (3) complex medication regimen; (5) risk for emotional or psychological distress due to personal losses; (6) unsuccessful prior placements; N. who has decision-making authority for the	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 74 resident, including: (1) the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and (2) the scope of decision-making authority of a substitute decision maker under subitem (1); and O. the need for follow-up referrals for additional medical or cognitive care by health professionals. On December 29, 2022, at 2:30 p.m. registered nurse (RN)-B verified she had not written weekly nurse's notes to include wound measurements and wound condition and stated she "saw R1's wound at least weekly, for a while the LPN [licensed practical nurse] and I were doing the dressing. I will need to write my notes better." RN-B confirmed the content of the Change of Condition assessment should have been completed with R1's COVID-19 infection and lacked the required content. Additionally, RN-B verified the licensee's "Client monitoring Visit Notes" were used as the RN 90 day Assessment tool and lacked the required content of a comprehensive RN assessment. R2 R2's diagnoses included basal cell carcinoma, diabetes mellitus, chronic kidney disease, benign prostatic hyperplasia, and urinary urge incontinence with presence of indwelling urinary catheter, mild memory disturbance, lymphedema due to venous insufficiency. R2's Service Plan Addendum dated August 22, 2022, included dressing, bathing, toileting assistance, medication management, blood glucose checks, catheter assistance, insulin injections and bowel tracking. 90 DAY ASSESSMENTS	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 75 R2's 90 day assessments lacked the required content for comprehensive monitoring and review and lacked documented physical assessment of the resident at the time of review. R2's record included the following assessments -dated May 30, 2022, Client Monitoring Visit Notes -dated August 22, 2022, Client Monitoring Visit Notes, with note, "Client has COVID. We are monitoring him. Services will not change." -dated November 20, 2022, Client Monitoring Visit Notes The above Client Monitoring Visit Notes sheet indicated "documentation for client must be completed no more than 90 days from the previous visit" and included "services reviewed" for housekeeping, personal hygiene, dressing, bathing, med reminders, med administration and other topics; are all home care services being performed adequately; nursing assessment revised; care plan/services appropriate for the clients needs; are the services appropriate to the clients needs; client/family problem, concerns, or comments; unlicensed staff present; family member present. Documentation by RN-B on the sheets identified "N" (no) was circled for response to nursing assessment was revised. The sheets lacked documented evidence of physical assessment of R2 by RN-B and comprehensive review of all required content. CHANGE IN CONDITION ASSESSMENTS R2's record lacked a comprehensive RN assessment with a change in condition with a COVID-19 infection and following a hospitalization. R2's nurse's notes included the following entries:	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 76 -dated August 22, 2022, [R2's] blood sugar remain high and results are faxed to [clinic name]. [R2] has a cold today. We checked for COVID-19 and he is positive. Isolation precautions in place. His family is notified. -dated August 23, 2022, [R2] has been in his apt. with services delivered to him. Standard precautions continue for COVID-19. Temp (temperature) today is 36.8, HR-81, O2- sats 93%, B/P- 103/67. He states "I've been a lot sicker in my life." Got a dry non productive cough. Breath sounds are clear. Report called to his daughter [name]. -dated August 29, 2022, Catheter change done by nurse today. He had a lot of discomfort with insertion. Not a lot of output. Tonight staff called to say his catheter has no drainage. His B/P is low and he had an emesis. Ambulance called and he's transported to [hospital name] for evaluation. His family are notified. -dated August 30, 2022, [R2] is hospitalized for possible UTI and low blood pressure. -dated September 6, 2022, [R2] returned from hospital today. He's doing well and has responded well to treatment in the hospital. His Foley cath (catheter) was changed in the hospital. R2's Client Monitoring Visit notes dated August 22, 2022, indicated R2 had COVID-19; however, the licensee's RN failed to complete a Comprehensive Assessment for a Change in Condition. R2's hospital discharge summary dated September 6, 2022, hospital course summary included: patient's blood and urine cultures returned with pan-susceptible Citrobacter koseri. Patient was deemed medically stable for discharge back to his senior living center on September 6, 2022. Follow up was arranged with	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 77 Urology and his PCP (primary care provider). The licensee's RN failed to complete a Comprehensive Assessment for a Change in Condition related to this hospitalization. On December 29, 2022, at 2:40 p.m. RN-B verified the licensee's "Client monitoring Visit Notes" were used as the RN 90 day Assessment tool and lacked the required content of a Comprehensive RN Assessment. RN-B stated "No, probably not done." in reference to completing a Comprehensive Assessment for a Change in Condition following R2's hospitalization. R3 R3's diagnoses included Type 2 diabetes mellitus, obstructive sleep apnea (intermittent airflow blockage during sleep), left ventricular hypertrophy (a thickening of the wall of the hearts main pumping chamber), major depressive disorder, generalized anxiety, chronic bilateral low back pain, hypertension, essential tremor, and early onset Alzheimer's dementia (progressive mental deterioration which occurs in someone under age 65). R3's Service Plan Addendum dated August 4, 2022, included assessments, dressing, bathing, transfers, wheeling, continence assist with toileting, medication administration, treatments "add to Med [medication]/Tx [treatment]/Therapy plan", behavior monitoring or intervention, housekeeping and linens, personal laundry, spot/safety checks, oral care, activities escort, nail care assistance and safety assistance call pendant. R3's Individualized Treatment or Therapy	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 78 Management Plan dated August 4, 2022, (as referenced in R3's Service Plan Addendum) indicated "statement of the type of services that will be provided (check all that apply)" included "blood glucose monitoring" and "CPAP" (continuous positive airway pressure) (a machine that uses mild airway pressure to keep breathing airways open while you sleep). R3's assessment for change of condition dated August 4, 2022, identified "indicate level of assistance needed for skin care" was "A. N/A [not applicable]; no skin concerns needing treatment or monitoring". R3's record lacked documented evidence of comprehensive nursing assessments by the RN with development of new pressure ulcer wound (size, appearance, odor, drainage, pain). On December 28, 2022, at 8:14 a.m. R3 was observed to have heel protectors on both feet. ULP-D stated R3 wore the heel protectors due to R3 has "sores on bottom of feet on heels". ULP-D stated R3 "kicks them off every once in a while". At 9:16 a.m., observation of R3's heels with ULP-D revealed an adhesive dressing was in place on the outer side of R3's left heel. R3's skin was intact on right heel. ULP-D showed the evaluator a box of Optifoam gentle EX silicone faces foam and border dressings (absorbent dressing) on R3's bathroom sink countertop. ULP-D stated, "We [the ULP] put on heel". Two tubes of Thera honey gel (promotes natural debridement; removal of dead tissue from a wound) was observed on top of R3's bathroom sink countertop. ULP-D stated the night shift ULP apply the Thera honey gel and dressing to R3's heel and Hospice applied on R3's shower day.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 79 On December 28, 2022, at 9:20 a.m. RN-B stated R3 "developed the blister to left heel after [R3] started on Hospice". R3 wore shoes prior and when the blister developed the "heel protectors" were implemented. RN-B stated the Hospice physician was notified. RN-B stated she had "measured the blister in the beginning" with the Hospice RN (RN-G). RN-B stated she "had not lately looked at" R3's wound on left heel. RN-B stated, "I have seen it, not measured it." RN-B stated, "[RN-G] stated Hospice would take care of the treatment for the left heel blister". On December 28, 2022, at 12:20 p.m. RN-G stated Hospice supplied foam booties for R3 to wear on heels. RN-G further stated "me or LPN" (licensed practical nurse) assessed R3's wound on left heel two times a week and "PRN gets changed almost daily by the ULP [facility staff] because gets rubbed off". RN-G stated R3's wound on left heel when first noticed was "eschar bed [dead tissue that eventually sloughs off of healthy skin after an injury), Thera honey applied and sloughed off". RN-G stated R3's left heel wound was "light ulceration some sort, likely pressure, stage one (intact skin with non blanchable redness of a localized area usually over a boney prominence). It took eschar about one month to disappear". RN-G stated the treatment for R3's left heel wound was "cleanse and dry the wound bed, apply Thera honey on the wound bed and apply Optifoam 3 X 3" dressing. R3's record identified the following information for R3's left heel pressure ulcer wound: -Notes dated August 9, 2022, R3 "has developed a blister on her left heel. Hospice is aware of it and are taking care of it." -Notes dated August 11, 2022, "Hospice services here to see [R3]. Dressing done to heel by	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 80 [Hospice] RN." -Hospice order dated November 3, 2022, "order description: unstageable pressure ulcer to the left heel. Current measures on 11/3/2022 of 1.7 cm [centimeters] X [by] 1 cm X 0 cm. Cleanse with wound cleanser, pat dry, apply barrier cream to surrounding edges of eschar tissue and then cover with 3 x 3 Optifoam, [Hospice] RN to assess 2 X [two times] weekly and change and PRN [as needed] as needed by facility staff". R3's record lacked documented evidence of comprehensive assessment of pressure ulcer wound to left heel with development, including consistent weekly assessment to include size, appearance, odor, drainage and pain. On December 29, 2022, at 12:30 p.m. LALD-A and RN-B stated they were "not aware there was verbal communication about it" from Hospice in regards to the facility staff assisting with R3's dressing changes to left heel wound. 90 DAY ASSESSMENTS R3's 90 day assessments lacked required content for comprehensive monitoring and review, lacked documented physical assessment of the resident at time of review and lacked accurate documented information with review. R3's record included the following assessments: -dated December 10, 2021, Client Monitoring Visit Notes -dated March 7, 2022, Client Monitoring Visit Notes -dated June 1, 2022, Client Monitoring Visit Notes -dated August 4, 2022, Client Monitoring Visit Notes -dated August 4, 2022, assessment for change of condition	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 81 -dated November 2, 2022, Client Monitoring Visit Notes The above assessment for change of condition lacked documented review of required content for the following: B. activities of daily living, including: (1) toileting pattern D. physical health status, including: (2) allergies and sensitivities related to medication, seasonality, and environment and if any of the allergies or sensitivities are life threatening; (3) infectious conditions; (4) a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (a) the reason taken; (b) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; (c) the dosage; (d) the frequency of use; (e) the route administered or taken; (f) any difficulties the resident faces in taking the medication; (i) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and (j) provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; (6) a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months;	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 82 (7) weight; M. risk indicators, including: (3) complex medication regimen; (5) risk for emotional or psychological distress due to personal losses; (6) unsuccessful prior placements; N. who has decision-making authority for the resident, including: (1) the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and (2) the scope of decision-making authority of a substitute decision maker under subitem (1); and O. the need for follow-up referrals for additional medical or cognitive care by health professionals. The above Client Monitoring Visit Notes sheet indicated "documentation for client must be completed no more than 90 days from the previous visit" and included "services reviewed" for housekeeping, personal hygiene, dressing, bathing, med reminders, med administration and other topics; are all home care services being performed adequately; nursing assessment revised; care plan/services appropriate for the clients needs; are the services appropriate to the clients needs; client/family problem, concerns, or comments; unlicensed staff present; family member present. Documentation by RN-B on the sheets identified "N" (no) was circled for response to nursing assessment was revised. The sheets lacked documented evidence of physical assessment of R3 by RN-B and comprehensive review of all required content. In addition, R3's assessment for change of condition dated August 4, 2022, identified on page 18 RN-B documented "No" response for "Is the resident diabetic and did not identify R3 required blood sugar check once weekly. R3's	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 83 assessment lacked accurate documentation for assessment of diagnosis of diabetes and requiring blood sugar check. On December 29, 2022, at 12:30 p.m. LALD-A and RN-B reviewed R3's assessments and stated, "We will add that", the assessment was not "explicit" with areas required or "we don't have that" in the assessment, regarding the facility's master assessment lacked the above required content for review. RN-B stated she completed a physical assessment of the resident at the time the assessments were completed, but did not document the information. LALD-A and RN-B confirmed the assessments lacked documented evidence of physical assessment of R3. RN-B verified R3's assessment for change of condition dated August 4, 2022, lacked accurate documented review for diabetes and blood sugar check. CHANGE IN CONDITION R3's record lacked documented evidence of comprehensive monitoring and review for changes in condition. R3's record identified the following: -Notes dated March 3, 2022, R3 will be discharged from the hospital today and be returning. She has had a couple of medication changes and will start having occupational/physical therapy. -Discharge Summary hospital dated March 3, 2022, indicated stable for discharge and diagnoses recurrent falls. -Emergency Room (ER) After Visit Summary dated July 20, 2022, indicated start taking on July 21, 2022, Duricef (antibiotic) 2 capsules (1,000 milligrams) two times daily for five days for urinary tract infection.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 84 -Discharge Summary hospital print date July 25, 2022, indicated date of admission was July 22, 2022. R3's record included the following assessments: -dated December 10, 2021, Client Monitoring Visit Notes -dated March 7, 2022, Client Monitoring Visit Notes -dated June 1, 2022, Client Monitoring Visit Notes -dated August 4, 2022, Client Monitoring Visit Notes -dated August 4, 2022, assessment for change of condition On December 29, 2022, at 12:30 p.m. LALD-A and RN-B reviewed R3's record and assessments completed as noted above. RN-B verified there were no comprehensive monitoring and review reassessments completed for the above changes in condition for R3. RN-B stated, "I usually would, I may have missed". RN-B confirmed the assessment dated March 7, 2022, was a regular scheduled 90 day assessment. The evaluator requested R3's facility progress notes for the dates of May 30, 2022, through July 25, 2022. On December 30, 2022, at 10:49 a.m. LALD-A stated, "We can't find notes for those dates" referring to R3's "Notes" documented by staff for the dates between May 30, 2022, and July 25, 2022. FALL R3's record lacked documented review for causative factors and implementation of intervention related to fall. R3's Incident Center report dated December 16,	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 85 2022, at 7:25 p.m. indicated fall unwitnessed. "After helping aide put another resident to bed we were walking back and noticed that the resident 112 [R3] was laying face down on her floor. Called other aides for back up to get her turned over and back in chair. [R3] said she was reaching for something and toppled over. When we sat resident up on floor took her vitals (blood pressure, temperature, oxygen saturation, pulse). Resident didn't complain of any pain. MOC [manager on call] and RN called. Staff assisted her back into her chair with no issue. Resident's room." December 16, 2022, documented by RN-B, check R3 over. No injuries observed. Vital signs (blood pressure, temperature, heart rate, respiration) were documented. R3's Notes dated December 16, 2022, indicated R3 slipped out of Broda chair onto floor in sitting area. The worker assisted her back into chair with other staff person assisting also. Checked over for any injuries. None observed. Hospice notified. Vitals (blood pressure, pulse, temperature, respirations) were documented. R3's record lacked evidence the RN had conducted assessment of the fall for causative factors, including implementation of interventions from review of causative factors to minimize the risk for future falls and potential injury. On December 30, 2022, at 9:20 a.m. LALD-A stated, that was "all the documentation the facility had" for R3's fall as noted above. The licensee's Assessments, Reviews, and Monitoring policy dated July 27, 2022, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01620	Continued From page 86 person (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment. 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, 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.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 87 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three resident's (R3) service plan was revised to reflect the current services provided. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included Type 2 diabetes mellitus and early onset Alzheimer's dementia (progressive mental deterioration which occurs in someone under age 65). R3's Service Plan Addendum dated August 4, 2022, indicated R3 received services including assessments, dressing, bathing, transfers, wheeling, continence assist with toileting, medication administration, treatments "add to Med [medication]/Tx [treatment]/There [therapy] plan", behavior monitoring or intervention, housekeeping and linens, personal laundry, spot/safety checks, oral care, activities escort, nail care assistance and safety assistance call pendant. R3's Individualized Treatment or Therapy Management Plan dated August 4, 2022, (as referenced in R3's Service Plan Addendum) indicated "statement of the type of services that	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 88 will be provided (check all that apply)" included "blood glucose monitoring" (use of glucose meter for testing the concentration of glucose (main sugar) in the blood) and "CPAP" (continuous positive airway pressure) (a machine that uses mild airway pressure to keep breathing airways open while you sleep). R3's assessment for change of condition dated August 4, 2022, indicated no skin concerns needing treatment or monitoring. R3 required physical assist of two for transfers/getting in and out of bed/toileting, was independent with grooming, required physical assist with oral hygiene/nail care and needed frequent redirection for moderate disorientation to person, place or time. On December 27, 2022, at 3:00 p.m. ULP-D stated staff dressed R3, toileted R3 every three hours with change of incontinent product, staff used an EZ stand (mechanical lift) to transfer R3, R3 could brush her own teeth with assist to set up and reminder and staff comb R3's hair. On December 28, 2022, at 8:14 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R3 who was seated in a Broda chair (a positioning wheelchair). R3 was observed to have heel protectors on both feet. ULP-D stated R3 wore the heel protectors because R3 has "sores on bottom of feet on heels". ULP-D stated R3 "kicks them off every once in a while". At 9:16 a.m., observation of R3's heels with ULP-D revealed an adhesive dressing was in place on the outer side of R3's left heel. R3's skin was intact on right heel. ULP-D showed the evaluator a box of Optifoam gentle EX silicone faces foam and border dressings (absorbent dressing) on R3's bathroom sink countertop.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 89 ULP-D stated, "We [the ULP] put on heel". Two tubes of Thera honey gel (promotes natural debridement; removal of dead tissue from a wound) was observed on top of R3's bathroom sink countertop. ULP-D stated the night shift ULP apply the Thera honey gel and dressing to R3's heel and Hospice applied on R3's shower day. On December 28, 2022, at 9:20 a.m. registered nurse (RN)-B stated R3 "developed the blister to left heel after [R3] started on Hospice". R3 wore shoes prior and when the blister developed the "heel protectors" were implemented. RN-B stated the Hospice physician was notified. RN-B stated she had "measured the blister in the beginning" with the Hospice RN (RN-G). RN-B stated she "had not lately looked at" R3's wound on left heel. RN-B stated, "I have seen it, not measured it." RN-B stated, "[RN-G] stated Hospice would take care of the treatment for the left heel blister". On December 28, 2022, at 12:20 p.m. RN-G stated Hospice supplied foam booties for R3 to wear on heels. RN-G stated Hospice nurse "me or LPN" (licensed practical nurse) assessed R3's wound on left heel two times a week and "PRN get's changed almost daily by the ULP [facility staff] because get's rubbed off". RN-G stated R3's wound on left heel when first noticed was "eschar bed [dead tissue that eventually sloughs off of healthy skin after an injury), Thera honey applied and sloughed off". RN-G stated R3's left heel wound was "light ulceration some sort, likely pressure, stage one [intact skin with non blanchable redness of a localized area usually over a boney prominence]. It took eschar about one month to disappear". RN-G stated the treatment for R3's left heel wound was "cleanse and dry the wound bed, apply Thera honey on the wound bed and apply Optifoam 3 X 3" dressing.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 90 R3's record identified the following information for R3's left pressure ulcer wound: -Notes dated August 9, 2022, R3 "has developed a blister on her left heel. Hospice is aware of it and are taking care of it." -Notes dated August 11, 2022, "Hospice services here to see [R3]. Dressing done to heel by [Hospice] RN." -Hospice order dated November 3, 2022, "order description: unstageable pressure ulcer to the left heel. Current measures on 11/3/2022 of 1.7 cm [centimeters] X [by] 1 cm X 0 cm. Cleanse with wound cleanser, pat dry, apply barrier cream to surrounding edges of eschar tissue and then cover with 3 x 3 Optifoam, [Hospice] RN to assess 2 X [two times] weekly and change and PRN [as needed] as needed by facility staff". R3's Care Tracking Sheet dated December 2022, identified staff were signing for providing the services of activities escort, ambulation/transfer full assist, bathing full assist, behavior intervention, dressing full assist, housekeeping, laundry, medication assist, nail care assist, oral care assist, CPAP assist, safety assistance, toileting assistance and whereabouts check. R3's service plan lacked revision for the service of assistance with treatments of dressing change to left heel pressure wound/heel protectors, grooming-assist with hair care, positioning, bed mobility, orientation-assist with orientating to person, place, time, meals and socialization/group and individual . On December 29, 2022, at 12:30 p.m., licensed assisted living director (LALD)-A and RN-B stated they were "not aware there was verbal communication about it" from Hospice, regarding	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 91 the facility staff were assisting with R3's dressing changes to left heel wound. RN-B stated the left heel pressure wound dressing changes and heel protectors were treatments ordered by Hospice. LALD-A and RN-B reviewed R3's service plan and Individualized Treatment Plan and verified R3's service plan lacked the treatment services of dressing change to left heel pressure wound/heel protectors, grooming-assist with hair care, positioning, bed mobility, orientation-assist with orientating to person, place, time, meals and socialization/group and individual. The licensee's Service Plan policy dated July 27, 2022, indicated "service plans, shall be revised, if needed, based on resident reassessments and monitoring." A service plan would include a description of the services that are to be provided based on the most recent assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01650	Continued From page 92 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 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 three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 had diagnoses to include diabetes mellitus (a chronic condition that affects the way the body	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01650	Continued From page 93 processes blood sugar (glucose), stage four sacral pressure injury with history of osteomyelitis (an infection/inflammation in the bone), benign prostatic hyperplasia with lower urinary tract symptoms (enlarge prostate resulting in recurrent urinary tract infections, and giant cell arteritis (inflammation of the lining of the arteries, often affecting arteries in the head which can result in blindness). R1's Service Plan Addendum dated September 14, 2022, indicated R1 received services to include medication administration, blood glucose checks, wound care and daily safety checks. On December 28, 2022, at 8:15 a.m. unlicensed personnel (ULP)-F was observed to assist R1 with medication administration, blood glucose check, and wound care. R1's Service Plan Addendum lacked the following: -the schedule and methods of monitoring assessments of the resident (lacked accurate time frame for initial assessment). R2 R2's diagnoses included basal cell carcinoma, diabetes mellitus, chronic kidney disease, benign prostatic hyperplasia, and urinary urge incontinence with presence of indwelling urinary catheter, mild memory disturbance, lymphedema due to venous insufficiency. R2's Service Plan Addendum dated August 22, 2022, indicated he received services to include dressing, bathing, toileting assistance, medication management, blood glucose checks, catheter assistance, insulin injections and bowel tracking.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01650	Continued From page 94 On December 28, 2022, at 8:30 a.m. ULP-F indicated ULP provided services to include twice daily blood glucose checks, medication administration including insulin injections, urinary catheter care to include urinary bag management, and catheter site cleansing, dressing, and bathing assistance, and assistance with transfers. R2's Service Plan addendum lacked the following: - the schedule and methods of monitoring assessments of the resident (lacked accurate time frame for initial assessment). R3 R3's diagnoses included Type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar) and early onset Alzheimer's dementia (progressive mental deterioration which occurs in someone under age 65). R3's Service Plan Addendum dated August 4, 2022, indicated R3 received services including assessments, dressing, bathing, transfers, wheeling, continence assist with toileting, medication administration, treatments "add to Med [medication]/Tx [treatment]/There [therapy] plan", behavior monitoring or intervention, housekeeping and linens, personal laundry, spot/safety checks, oral care, activities escort, nail care assistance and safety assistance call pendant. R3's Individualized Treatment or Therapy Management Plan dated August 4, 2022, (as referenced in R3's Service Plan Addendum) indicated "statement of the type of services that will be provided (check all that apply)" included "blood glucose monitoring" (use of glucose meter for testing the concentration of glucose (main	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01650	Continued From page 95 sugar) in the blood) and "CPAP" (continuous positive airway pressure) (a machine that uses mild airway pressure to keep breathing airways open while you sleep). In addition, the service plan indicated for "monitoring and reassessment schedule Initial within 5 days" and the box next to "advanced directives/POLST state no emergency medical services" had an X marked. On December 27, 2022, at 3:00 p.m. ULP-D stated staff dressed R3, toilet R3 every three hours with change of incontinent product, staff used an EZ stand (mechanical lift) to transfer R3, R3 could brush her own teeth with assist to set up and reminder and staff comb R3's hair. On December 28, 2022, at 8:14 a.m., ULP-D was observed to administer medications to R3 who was seated in a Broda chair (a positioning wheelchair). R3 was observed to have heel protectors on both feet. ULP-D stated R3 wore the heel protectors due to R3 has "sores on bottom of feet on heels". ULP-D stated R3 "kicks them off every once in a while". At 9:16 a.m., observation of R3's heels with ULP-D revealed an adhesive dressing was in place on the outer side of R3's left heel. R3's skin was intact on right heel. ULP-D showed the evaluator a box of Optifoam gentle EX silicone faces foam and border dressings (absorbent dressing) on R3's bathroom sink countertop. ULP-D stated, "We [the ULP] put on heel". Two tubes of Thera honey gel (promotes natural debridement; removal of dead tissue from a wound) was observed on top of R3's bathroom sink countertop. ULP-D stated the night shift ULP apply the Thera honey gel and dressing to R3's heel and Hospice applied on R3's shower day. On December 28, 2022, at 9:20 a.m. RN-B stated	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01650	Continued From page 96 R3 "developed the blister to left heel after [R3] started on Hospice". R3 wore shoes prior and when the blister developed the "heel protectors" were implemented. RN-B stated the Hospice physician was notified. RN-B stated she had "measured the blister in the beginning" with the Hospice RN (RN-G). RN-B stated she "had not lately looked at" R3's wound on left heel. RN-B stated, "I have seen it, not measured it." RN-B stated, "[RN-G] stated Hospice would take care of the treatment for the left heel blister". On December 28, 2022, at 12:20 p.m. RN-G stated Hospice supplied foam booties for R3 to wear on heels. RN-G stated Hospice nurse "me or LPN" (licensed practical nurse) assessed R3's wound on left heel two times a week and "PRN get's changed almost daily by the ULP [facility staff] because get's rubbed off". R3's Service Plan Addendum lacked the following: - description of services for treatments (grooming - assist with hair care, positioning and bed mobility, wound care, orientation - assist with orientating to person, place, time, meals, socialization/group and individual) - the fees for services and the frequency of each service (grooming - assist with hair care, positioning and bed mobility, wound care, orientation - assist with orientating to person, place, time, meals, socialization/group and individual). - the schedule and methods of monitoring assessments of the resident (lacked accurate time frame for initial assessment). - a contingency plan that includes: (iv) the circumstances in which emergency medical services are not to be summoned	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01650	Continued From page 97 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters (lacked Hospice service marked, lacked indication of code status (Full Code or Do Not Resuscitate) and lacked indication if R3 had a living will or not). On December 29, 2022, at 12:30 p.m. LALD-A and RN-B stated they were "not aware there was verbal communication about it" from Hospice, regarding the facility staff were assisting with R3's dressing changes to left heel wound. RN-B stated the left heel pressure wound dressing changes and heel protectors were treatments ordered by Hospice. LALD-A and RN-B verified R3's service plan lacked the above content. LALD-A verified the assessment schedule for initial assessment of residents on the licensee's service plan utilized for all residents was inaccurate. The licensee's Service Plan policy dated July 27, 2022 indicated "service plans, shall be revised, if needed, based on resident reassessments and monitoring". A service plan would include a description of the services that are to be provided based on the most recent assessment and resident preferences, fees for the services to be provided, the frequency of each service to be provided, a schedule and method for the next planned assessment or monitoring and how the facility will support documented resident health care directive decisions if any, including circumstances when emergency medical services are not to be summoned. Other documents such as care plan, assignment sheets or other internal documents may be used to assist staff in understanding their daily assignments and tasks, but such documents are not required and do not replace the required service plan.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01650	Continued From page 98 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure reassessment of medication management services at a minimum annually included all required content for three of three residents (R1, R2, R3). 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). R1 R1 had an admission date of November 23, 2021, with diagnoses including diabetes mellitus, stage four sacral pressure injury with history of osteomyelitis (an infection/inflammation in the bone), benign prostatic hyperplasia with lower	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01710	Continued From page 99 urinary tract symptoms (enlarge prostate resulting in recurrent urinary tract infections, and giant cell arteritis (inflammation of the lining of the arteries, often affecting arteries in the head which can result in blindness). R1's Service Plan dated September 14, 2022, indicated R1 received services to include medication administration, blood glucose checks, wound care and daily safety checks. On December 28, 2022, at 8:15 a.m. unlicensed personnel (ULP)-F was observed to assist R1 with medication administration, blood glucose check, and wound care. R1's assessment dated September 12, 2022, identified as a Change in Condition Assessment (post hospitalization), indicated R1 required ULP assistance with oral medication administration up to three times daily, and insulin injection by ULP one time daily. The assessment did not indicate another document to reference regarding medications R1 was receiving and lacked the required content of a medication review to include: - physical health status, including: - a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: - the reason taken; - any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - the dosage; - the frequency of use; - the route administered or taken; - any difficulties the resident faces in taking the medication;	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01710	Continued From page 100 - interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and - provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; R1's record lacked a medication reassessment by the registered nurse (RN) conducted face-to-face with the resident, with the following required content: -documentation the assessment was conducted face-to-face with the resident; and -identification and review of indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues -identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On December 29, 2022, at 1:25 p.m. RN-B indicated she reviewed medications with the pharmacist regarding contraindications and side effects. R2 R2 had an admission date of August 12, 2021, with diagnoses including basal cell carcinoma, diabetes mellitus, chronic kidney disease, benign prostatic hyperplasia, and urinary urge incontinence with presence of indwelling urinary	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01710	Continued From page 101 catheter, mild memory disturbance, lymphedema due to venous insufficiency. R2's assessment dated August 12, 2021, at time of admission indicated R2 required assistance with medication administration. In the section labeled Medication Assistance, the record indicated R1 needed assistance with medication administration. In the section labeled Medication Management, the document indicated ULP provided oral medication assistance up to three times daily. In the section labeled Diabetes Mellitus, under 1. Is the resident diabetic? the answer "yes" was circled. Under 1.b1. Insulin injections, no options were circled, and under 1.b2. Fingerstick Blood Glucose, option A. no insulin injections was circled. R2's Service Plan Addendum dated August 22, 2022, indicated he received services to include medication management, blood glucose checks, and insulin injections. R2's medication administration record (MAR) dated December 2022, indicated he received medications to include three medications for diabetes (insulin injections), one for gastrointestinal reflux, one for cholesterol, one for prostate, two for mild pain, one for dry eyes, and two skin creams. On December 28, 2022, at 8:30 a.m. ULP-F indicated ULP provided services to include twice daily blood glucose checks, and medication administration including insulin injections. R2's record included a document named Client Monitoring Visit Notes, the licensee indicated was used as the 90 day assessment tool. The document indicated one line to include "Med	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01710	Continued From page 102 Administration" with an "X" in the column under the heading "Discussed". This document was completed on the following dates May 30, 2022, August 22, 2022, and November 20, 2022. R2's medication assessments as listed, failed to indicate R2 received insulin injections. Additionally, the documents considered assessments, did not reference another document indicating the medications R2 was receiving. The document above lacked the required content of a medication assessment to include: -the identification and review of all medications the resident is known to be taking; - indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - the dosage; - the frequency of use; - the route administered or taken; - any difficulties the resident faces in taking the medication - interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. R2's record lacked a medication reassessment by the RN conducted face-to-face with the resident, with the following required content: -documentation the assessment was conducted face-to-face with the resident; and -identification and review of indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01710	Continued From page 103 -identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On December 29, 2022, at 2:45 p.m. regarding R2's medication plan and assessment, RN-B stated she would need to look, as it was likely overlooked. On December 30, 2022, at 9:00 a.m. RN-B provided another treatment plan but no medication plan or assessment. No further information was provided. R3 R3 had an admission date of June 7, 2021, with diagnoses including Type 2 diabetes mellitus and early onset Alzheimer's dementia (progressive mental deterioration which occurs in someone under age 65). R3's Service Plan Addendum dated August 4, 2022, indicated R3 received medication management. On December 28, 2022, at 8:14 a.m. ULP-D was observed to administer medications to R3. R3's assessment for change of condition dated August 4, 2022, indicated R3 required assist with medication administration and R3 had "No" preference in how to take medication; assessment for self administration of medication indicated R3 was unable to self administer medications safely without assistance, staff would administer oral medications four times daily. The assessment did not reference another document for reference of a list of medications R3 was	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01710	Continued From page 104 receiving and lacked documented review of required content for the following: D. physical health status, including: (4) a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (a) the reason taken; (b) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; (c) the dosage; (d) the frequency of use; (e) the route administered or taken; (f) any difficulties the resident faces in taking the medication; (i) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and (j) provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; R3's Medication Record dated December 2022, indicated staff were administering one medication used for back pain, two for constipation, one for nausea and vomiting, one for secretions, one for mild pain or fever, one for loose bowel movements, one for high cholesterol, one for diabetes, two vitamin supplements, one for Alzheimer's dementia, one for anxiety, two for depression, and one for pain. R3's record lacked a medication reassessment by the RN conducted face-to-face with the resident, with the following required content: -documentation the assessment was conducted	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01710	Continued From page 105 face-to-face with the resident; and -identification and review of indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues -identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On December 29, 2022, at 12:30 p.m. LALD-A and RN-B verified R3's record lacked medication reassessment for the above content. LALD-A further verified the same assessment tool was used for all residents receiving medication services. The licensee's Medication Management Assessment Monitoring and Reassessment policy dated August 1, 2021, indicated prior to providing medication management services the licensee would have a registered nurse conduct an assessment to determine what medication management services would be provided and how the services would be provided. The assessment referenced statue/rule 144G.71 Subd. 2 and 3. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01710		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01730	Continued From page 106 (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01730	Continued From page 107 professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individualized medication management plan to include all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 had diagnoses to include diabetes mellitus, stage four sacral pressure injury with history of osteomyelitis (an infection/inflammation in the bone), benign prostatic hyperplasia with lower urinary tract symptoms (enlarge prostate resulting in recurrent urinary tract infections, and giant cell arteritis (inflammation of the lining of the arteries, often affecting arteries in the head which can result in blindness). R1's Service Plan dated September 14, 2022, indicated R1 received services to include medication administration. On December 28, 2022, at 8:15 a.m. unlicensed	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01730	Continued From page 108 personnel (ULP)-F was observed to assist R1 with medication administration, blood glucose check, and wound care. R1's Individualized Medication Management Plan dated November 25, 2022, indicated "medication administration by facility staff; Set-up of medication by pharmacist; medications stored in locked medication room; there are medications with special manufacturer's instructions: Basaglar [insulin injection] requires refrigeration; client specific instructions: takes medications whole; the facility nurse is responsible for monitoring supplies and ordering refills; medications delegated to ULP: oral, subcutaneous [injection]; nurse notification of problems or concerns: ULP to contact the licensed nurse 24/7 with any questions or concerns with medication administration; documentation related to medications are located on the MAR; verifications of medications administered as prescribed or ordered are located on the MAR; monitoring of medications to prevent possible complications or adverse reactions can be found: on resident chart as appropriate." R1's Medication Administration Record (MAR) dated December 2022, indicated medications to include two for prostate, three for diabetes management, one for water retention, one for cholesterol, one for heart health, one supplement, two for heartburn, one for wound healing, one for wound cleansing, one for mild pain, and one antihistamine. R1's Individualized Medication Management Plan lacked identification of medication management tasks that may be delegated to ULP to include the routes of: topical, eye, inhalation and ear medications; lacked parameters for antacid	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01730	Continued From page 109 dosing; and lacked the description of the medications stored in the locked medication cart. R1's individualized medication management record lacked the following: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; and -identification of medication management tasks that may be delegated to unlicensed personnel. On December 29, 2022, at 2:30 p.m. registered nurse (RN)-B confirmed R1's Individualized Medication Management Plan lacked the required content. In reference to the antacid dosing parameters, RN-B stated "this would have come straight from the physician's order, the ULP usually call the nurse for direction, this is a rare order." R2 R2's diagnoses included basal cell carcinoma, diabetes mellitus, chronic kidney disease, benign prostatic hyperplasia, and urinary urge incontinence with presence of indwelling urinary catheter, mild memory disturbance, lymphedema due to venous insufficiency. R2's Service Plan Addendum dated August 22, 2022, indicated he received services to include medication management, blood glucose checks, and insulin injections. R2's medication administration record (MAR) dated December 2022, indicated he received medications to include three medications for diabetes, one for gastrointestinal reflux, one for	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01730	Continued From page 110 cholesterol, one for prostate, two for mild pain, one for dry eyes, and two skin creams. On December 28, 2022, at 8:30 a.m. ULP-F indicated ULP provided services to include twice daily blood glucose checks and medication administration including insulin injections. R2's record lacked an individualized medication plan/record and the required content to include: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01730	Continued From page 111 On December 27, 2022, at 2:00 p.m. the evaluator requested the licensed assisted living director (LALD)-A and RN-B for R2's record to include a Medication Plan. On December 29, 2022, at 2:45 p.m. the evaluator had not yet received the requested Medication Plan to which RN-B stated, "I will look, it probably was overlooked." On December 30, 2022, at 9:00 a.m. RN-B provided another copy of R2's Individualized Treatment or Therapy Management Plan dated August 22, 2022, and not the Medication Plan as requested. R3 R3's diagnoses included Type 2 diabetes mellitus and early onset Alzheimer's dementia (progressive mental deterioration which occurs in someone under age 65). R3's Service Plan Addendum dated August 4, 2022, indicated R3 received services which included medication management. On December 28, 2022, at 8:14 a.m. ULP-D was observed to administer medications to R3. ULP-D obtained R3's medications from a locked medication cart which was located inside a locked medication room. ULP-D crushed a total of nine medications and placed the medications in applesauce prior to administering the medications to R3. The medications observed to be crushed were vitamin B12 (used to treat deficiency), vitamin D3 capsule (used for supplement), memantine (used to treat Alzheimer's disease), buspirone (used for anxiety), aripiprazole (used for depression), bupropion (used for depression), hydromorphone (used for back pain), and metformin (used to treat diabetes).	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01730	Continued From page 112 R3's Individualized Medication Management Plan dated August 4, 2022, indicated "medication administration by facility staff; medications are stored in locked medication room; there are no medications with special manufacturer instructions for storage; client specific instruction: takes medications whole; facility nurse is responsible for monitoring supplies and ordering refills on a timely basis; oral was marked for medications that may be delegated to unlicensed personnel; Nurse notification of problems/concerns ULP will contact the licensed nurse 24/7 with any questions or concerns with medication administration; documentation related to medication administration are located: on the medication administration record; verification of medications administered as prescribed or ordered are located: on the medication administration record; monitoring of medications to prevent possible complications or adverse reactions can be found: on the medication administration record." R3's record/Individualized Medication Management Plan /Medication Record lacked resident specific instructions for crushing medications (which medications should be crushed or not crushed); lacked parameters for as needed (PRN) medication to use first for constipation (Bisacodyl suppository or senna plus); lacked parameters for hours apart to administer for scheduled hydromorphone and PRN hydromorphone; lacked hours apart for administration of PRN loperamide medication; lacked which PRN medication to use first for pain/fever (Tylenol suppository or Tylenol oral tablets); lacked description of medications locked in medication cart; and lacked medication tasks that may be delegated to unlicensed personnel for rectal and topical medications.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01730	Continued From page 113 R3's individualized medication management record lacked the following: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of medication management tasks that may be delegated to unlicensed personnel; On December 29, 2022, at 12:30 p.m. LALD-A and RN-B verified R3's record lacked the above. LALD-A stated the pharmacy creates the medication record for the facility and whatever was entered on the medication record was what the physician wrote for the medication order. LALD-A and RN-B stated regarding parameters for R3's medications "something we will speak to the doctor about". RN-B stated R3's medications were to be "crushed" and there were no directions on R3's medication record indicating which medications could be crushed or not crushed. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01730		
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	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01760	Continued From page 114	01760		

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 per prescriber orders; failed to transcribe a medication order as written and failed to document dosage of a medication for one of three residents (R3).

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 Service Plan Addendum dated August 4, 2022, indicated R3 received services which included medication management.

On December 28, 2022, at 8:14 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R3. ULP-D crushed a total of nine medications and placed the medications in applesauce prior to administering the medications to R3. The medications observed to be crushed were vitamin B12 (used to treat deficiency) 1,000

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01760	Continued From page 115 micrograms (mcg) two tablets; vitamin D3 5,000 international units (IU) (used for supplement), memantine 5 milligrams (mg) (used to treat Alzheimer's disease), buspirone 10 mg (used for anxiety), aripiprazole 5 mg one half tablet (used for depression), bupropion 100 mg (used for depression), hydromorphone 2 mg one half tablet (used for back pain), and metformin 500 mg (used to treat diabetes). ADMINISTRATION OF MEDICATION R3's Medication Record (MR) dated December 2022, included the following: -vitamin B-12 1,000 mcg take two tablets (2,000 mcg) once daily -memantine 5 mg one tablet twice daily -buspirone 10 mg one tablet twice daily -aripiprazole 5 mg take 1/2 tablet (2.5 mg) twice daily R3's prescriber orders dated December 14, 2022, and December 28, 2022, included the following: -vitamin B-12 1,000 mcg take one tablet twice daily -memantine 5 mg take one tablet daily -buspirone 10 mg take one tablet daily -aripiprazole 5 mg take one tablet by mouth daily The licensee failed to administer R3's medications as per prescriber's orders. TRANSCRIBE ORDERS R3's MR dated December 2022, included the following: -loperamide 2 mg take one capsule after each loose bowel movement R3's prescriber orders dated December 28, 2022, included the following: -loperamide 2 mg take one tablet every six hours	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01760	Continued From page 116 as needed R3's MR did not match the prescriber order. DOCUMENTED DOSAGE OF MEDICATION R3's MR dated December 2022, included the following: -senna plus take one tablet by mouth once daily as needed for constipation R3's prescriber orders dated December 28, 2022, included the following: -senna plus 8.6 mg-50 mg take one tablet daily as needed R3's MR lacked documented dosage for senna plus. On December 29, 2022, at 12:30 p.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B reviewed R3's MR and prescriber orders for medications and verified R3's record lacked the above. RN-B verified the above prescriber orders were R3's current orders for medications. LALD-A and RN-B stated all medication orders for R3 go through Hospice. LALD-A stated, "We are going to have to follow up. I see the confusion" with Hospice regarding R3's prescriber orders for medications. An email received from the licensee on January 2, 2022, at 6:17 p.m. from LALD-A indicated "we have been reviewing the medication error that you noted on interview for patient with initials [R3]. We are investigating this item and I wanted to let you know that the medication list/report that was submitted to you for review and which we received from hospice is seemingly incorrect for the client. We have a medication list from [R3's]	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01760	Continued From page 117 provider that shows that the medications she received at the time of your review are correct. However, we are doing a medication reconciliation review with Hospice to ensure they are on the same page. Hospice clarified that they typically only prescribe medications for comfort and the medications where there are discrepancies are not ones that hospice typically prescribes and would have continued off her primary physician's orders. A hospice RN we spoke to said that there is a possibility that the Hospice RN entered incorrect prescription information based on what is shown for current Dr. Orders, but again, we are continuing to investigate this with them. Our review with our pharmacy and per [R3's] current doctors orders, currently shows that she received the correct dosages at the time of your review. I can let you know when we have finalized the review, but I just wanted to let you know as you enter this information for the audit." The licensee's Medication and Treatment Orders policy dated August 1, 2021, indicated the 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. The licensed nurse would review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change in condition. A resident's MAR and TAR would be audited regularly by licensed nurse or designee for documentation compliance. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01790	Continued From page 118	01790		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01790	Continued From page 119 the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee's registered nurse (RN) failed to develop written procedures for medication management services during unplanned times away from home and failed to ensure training and competency evaluations for preparing medications for resident unplanned times away were completed as required for two of two unlicensed personnel (ULP-F, ULP-D). 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	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01790	Continued From page 120 or has the potential to affect a large portion or all of the residents). The findings include: TRAINING/COMPETENCY ULP-F ULP-F had a hire date of May 17, 2021. On December 30, 2022, at 9:50 a.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B stated, "We send a list with the resident depending on the number of days. Staff can do if they've been trained." Regarding having a written procedure, RN-B stated, "We do, the ULP should know the policy/procedure. During staff meetings we cover different topics." With the requirement of staff needing to demonstrate competency, RN-B stated, "ok." ULP-F's record lacked evidence to indicate the RN provided training and determined competency to prepare and administer medications to residents for unplanned times away. ULP-D ULP-D had a hire date of August 31, 2022. On December 28, 2022, at 8:14 a.m. ULP-D was observed to administer medications to R3. At 9:16 a.m., ULP-D stated when a resident "goes out, we put medications in an envelope and send with the family". ULP-D further stated the staff write on the envelope "whose they are, what the med name is, time to give and staff initials". ULP-D stated "no copy" of a resident's medication record or other information was sent with the resident or family. ULP-D stated sending, "envelope with pills only." ULP-D's record lacked evidence to indicate the	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01790	Continued From page 121 RN provided training and determined competency to prepare and administer medications to residents for unplanned times away. On December 30, 2022, at 9:28 a.m. LALD-A and RN-B stated regarding the licensee's RN developed a written procedure for medication management services during unplanned times away from home for delegation to the licensee's ULP, "if knew ahead we do set up of meds". LALD-A and RN-B stated, "Yeah, they [ULP] can do" regarding sending medications with residents who leave the facility. LALD-A stated, "We don't have anything outside of policy" regarding a written procedure developed by the RN for the ULP to follow for the delegated task of administration of medications to residents for unplanned times away. LALD-A and RN-B reviewed ULP-D's employee record and verified ULP-D lacked documented evidence for training and determined competency to prepare and administer medications to residents for unplanned times away. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, read a registered nurse or licensed health professional may delegate tasks only to staff who are competent and possess the knowledge and skill consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. When the registered nurse or licensed health professional delegates tasks to ULP, that person will ensure that prior to the delegation the ULP 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. No further information was provided.	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01790	Continued From page 122 TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations in one of three refrigerators (2nd floor). Additionally, the licensee failed to ensure medications were securely stored for one of three (R3) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On December 27, 2022, at 11:00 a.m. during	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01880	Continued From page 123 entrance conference, registered nurse (RN)-B stated medications requiring refrigeration were stored in mini refrigerators in the locked medication rooms (three total-one on each floor of the assisted living and one in the memory care unit). On December 28, 2022, at 12:45 p.m. the evaluator and unlicensed personnel (ULP)-F completed a review of the contents and temperature of the mini-refrigerator located on the second floor of the assisted living. The evaluator observed an open freezer compartment filled with ice/frost build up, which then exposed multiple medications housed in the refrigerator to colder temperatures. The mini refrigerator lacked a thermometer. ULP-F stated she had never noticed a thermometer in the mini refrigerator and was unaware of any system to track and monitor the refrigerator temperature. Contents of the second floor mini-refrigerator included: -latanoprost eye drops (for glaucoma), one bottle with storage recommendations 68-77 degrees Fahrenheit (F); -erythromycin 0.5% eye ointment (antibiotic), one tube, with storage recommendations 59-86 degrees F; -basaglar 100 units/milliliter (u/ml) (insulin), seven pens, with storage recommendations 36-46 degrees F; -novolog flex pen (insulin) 100 u/ml, one pen with storage recommendations 36-46 degrees F; and -Trulicity (insulin) 3 mg/0.5 ml, 3 pens with storage recommendations 36-46 degrees F. On December 29, 2022, at 1:00 p.m. RN-B stated, "Typically the nurse puts the medications in the refrigerator and the pharmacy tells us	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01880	Continued From page 124 where to store the medications. It is in the works, we have plans to do." MEDICATIONS UNSECURED On December 28, 2022, at 8:14 a.m. ULP-D was observed to administer medications to R3 who was seated in a Broda chair (a positioning wheelchair). At the time of administration in R3's apartment, a bottle of Nystatin powder (used to treat types of fungus infections of skin) medication was observed to be located on a table by R3's bed. ULP-D stated the Nystatin powder was used for R3 "for folds belly". At 9:16 a.m., ULP-D showed the evaluator two Thera honey gel tubes of medication located on R3's bathroom sink. ULP-D stated the night shift staff applied the Thera honey get to R3's heel wound. On December 28, 2022, at 9:20 a.m. RN-B observed R3's apartment with the evaluator. RN-B stated, "Hospice said it was okay to leave there" regarding Thera honey gel two tubes observed on R3's bathroom sink. RN-B stated regarding the Nystatin powder bottle being stored on a table by R3's bed "no it's not supposed to be in here". The licensee's Medication Storage policy dated August 1, 2021, read when medications are managed and stored by [licensee name] medications will be kept securely locked and stored per manufacturer's directions. Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 125	01890		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to label time sensitive medications with an opened date for two of two residents (R1, R6) and failed to ensure labels on medication containers (house supply medicine) were legible. 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: SECOND FLOOR MEDICATION CART On December 28, 2022, at 12:30 p.m. the evaluator and unlicensed personnel (ULP)-F reviewed the contents of the second floor medication cart in the assisted living building of the facility.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 126 The following medications lacked the required opened date indication on the label: -R1's basaglar 100 units/milliliter (u/ml) insulin flex pen with recommendations to discard 28 days after opening; -R6's Ventolin HFA inhaler with recommendations to discard 12 months after removing it from the foil pouch; -R6's incruse ellipta 62.5 mg (inhaler) label indicated discard six weeks after opening. Additionally, a bottle of siltussin expectorant (cough medicine) labeled only as "house supply" lacked legible bottle label instructions. On December 29, 2022, at 1:00 p.m. registered nurse (RN)-B stated, "All staff are trained to write open dates on the white sticker as the pharmacy places for medications which have time limited use." MEMORY CARE MEDICATION CART The licensee failed to ensure date open for a eye drop medication and legible label for cough medication. On December 28, 2022, at 9:05 a.m. during observation of the medication cart in the memory care unit with ULP-D, a bottle of Latanoprost 0.005% eye drop medication was opened and being used for administration to a resident. The bottle had a sticker for date opened; however, no opened date was documented. ULP-D verified the findings. Two bottles of siltussin expectorant (used to relieve cough caused by common cold or other breathing illnesses) were observed to have faded labels making it unreadable. ULP-D verified at the time. ULP-D stated when looking at the labels, one bottle looked like it was "a resident's"	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 127 and the other bottle looked like facility "stock medication". ULP-D stated, "I think nurses" were responsible regarding checking medications for storage in the medication cart. On December 28, 2022, at 9:25 a.m. observation of the medication cart with RN-B stated, "Yes, should have date open for the eye drop medication". RN-B stated the eye drops were good to be used for 30 days once opened. RN-B stated the date on the eye drop label of being sent from the pharmacy was November 1, 2022. RN-B observed the two bottles of siltussin expectorant medication and stated "can't read labels" and she would "return to pharmacy" to be relabeled. The licensee's Medications-Prescription Drugs & Prohibition policy dated August 1, 2021, read when [licensee name] receives a prescription drug, prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 128 and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized treatment management plan to include all required content for two of three residents (R1, R3). 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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 129 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 27, 2022, at 10:00 a.m. licensed assisted living director (LALD)-A stated the licensee provided treatment management services to the licensee's residents. R1 R1 had diagnoses to include diabetes mellitus, stage four sacral pressure injury with history of osteomyelitis (an infection/inflammation in the bone), benign prostatic hyperplasia with lower urinary tract symptoms (enlarge prostate resulting in recurrent urinary tract infections, and giant cell arteritis (inflammation of the lining of the arteries, often affecting arteries in the head which can result in blindness). R1's Service Plan dated September 14, 2022, indicated R1 received services to include blood glucose checks and wound-care. R1's Wound Center visit note dated April 15, 2022, indicated a wound location of "coccyxgeal" (at the base of the tailbone), with measurements to include: "depth: full thickness; wound size: 4.2 cm [centimeters] length X [by] 1.2 cm wide X 3.7 cm deep; with moderate exudate [wound drainage]." R1's [licensee name] Dr. Appointment record dated November 7, 2022, indicated a Wound Clinic visit with the note "Wound clean, but	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 130 deeper. Continue BID [twice daily] dressings-Use 2 X [by]2 gauze opened up and moistened with Anasept wound cleanser, petroleum to periwound, ABD [dressing] and paper tape. Follow up in six (6) weeks." R1's wound care instructions dated November 8, 2022, read A.M. and P.M. shift to complete. 1. continue with dressing changes twice daily. 2. Gently remove old dressing. 3. Use 2 X 2 gauze opened up and moistened with Anasept wound cleaner (switched back to a diluted Dakins solution when the Anasept wound cleaner ran out). 4. Apply petroleum around wound. 5. Cover with ABD (absorbent dressing) and affix with medipore tape (a gentle skin tape). R1's Wound care documentation record dated November 29, 2022, through December 1, 2022, included the times of 9:00 a.m. and 5:00 p.m. as the designated times for R1's dressing changes. The ULP documented information for the following characteristics of the wound: drainage amount, drainage color, wound bed color, signs of infection, and peri area (other areas in the groin) skin integrity. R1's treatment and therapy management plan dated June 27, 2022, indicated R1 received treatments to include wound care, but lacked procedures for staff notifying a registered nurse (RN) when concerns arose with the treatment of R1's coccyx wound care. On December 29, 2022, at 2:30 p.m. RN-B verified R1's treatment plan lacked the instruction for when ULP should notify her with concerns with R1's wound care treatment. RN-B stated she, herself "saw the wound very often." R3	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 131 R3 diagnoses including Type 2 diabetes mellitus and early onset Alzheimer's dementia (progressive mental deterioration which occurs in someone under age 65). R3's Service Plan Addendum dated August 4, 2022, indicated R3 received services which included "Treatments, including weights, vital signs daily or weekly, CPAP [continuous positive airway pressure/a machine that uses mild airway pressure to keep breathing airways open while you sleep], blood glucose checks [use of glucose meter for testing the concentration of glucose (main sugar) in the blood], wound care, nebs, creams, insulin, etc. *Add to Med [medication]/Tx [treatment]/There [thera] plan". The statement on the service plan "Treatments, including weights, vital signs daily or weekly, CPAP, blood glucose checks, wound care, nebs, creams, insulin, etc. *Add to Med/There plan" was system wide for all resident service plans. R3's Individualized Treatment or Therapy Management Plan dated August 4, 2022, (as referenced in R3's Service Plan Addendum) indicated "statement of the type of services that will be provided (check all that apply)" included "blood glucose monitoring" (use of glucose meter for testing the concentration of glucose (main sugar) in the blood) and "CPAP" (continuous positive airway pressure) (a machine that uses mild airway pressure to keep breathing airways open while you sleep). On December 28, 2022, at 8:14 a.m. ULP-D was observed to administer medications to R3 who was seated in a Broda chair (a positioning wheelchair). R3 was observed to have heel protectors on both feet. ULP-D stated R3 wore the heel protectors due to R3 has "sores on	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 132 bottom of feet on heels". ULP-D stated R3 "kicks them off every once in a while". At 9:16 a.m., observation of R3's heels with ULP-D revealed an adhesive dressing was in place on the outer side of R3's left heel. R3's skin was intact on right heel. ULP-D showed the evaluator a box of Optifoam gentle EX silicone faces foam and border dressings (absorbent dressing) on R3's bathroom sink countertop. ULP-D stated, "We [the ULP] put on heel". Two tubes of Thera honey gel (promotes natural debridement; removal of dead tissue from a wound) was observed on top of R3's bathroom sink countertop. ULP-D stated the night shift ULP apply the Thera honey gel and dressing to R3's heel and Hospice applied on R3's shower day. On December 28, 2022, at 9:20 a.m. RN-B stated R3 "developed the blister to left heel after [R3] started on Hospice". R3 wore shoes prior and when the blister developed the "heel protectors" were implemented. RN-B stated the Hospice physician was notified. RN-B stated she had "measured the blister in the beginning" with the Hospice RN (RN-G). RN-B stated she "had not lately looked at" R3's left heel wound. RN-B stated, "I have seen it, not measured it." RN-B stated, "Hospice [RN-G] stated Hospice would take care of the treatment for the left heel blister". On December 28, 2022, at 12:20 p.m. RN-G stated Hospice supplied foam booties for R3 to wear on heels. RN-G stated Hospice nurse "me or LPN" (licensed practical nurse) assessed R3's wound on left heel two times a week and "PRN get's changed almost daily by the ULP [facility staff] because get's rubbed off". RN-G stated R3's wound on left heel when first noticed was "eschar bed [dead tissue that eventually sloughs off of healthy skin after an injury), Thera honey	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 133 applied and sloughed off". RN-G stated R3's left heel wound was "light ulceration some sort, likely pressure, stage one [intact skin with non blanchable redness of a localized area usually over a bony prominence]. It took eschar about one month to disappear". RN-G stated the treatment for R3's left heel wound was "cleanse and dry the wound bed, apply Thera honey on the wound bed and apply Optifoam 3 X 3" dressing. R3's record identified the following information for R3's left heel pressure ulcer wound: -Notes dated August 9, 2022, R3 "has developed a blister on her left heel. Hospice is aware of it and are taking care of it." -Notes dated August 11, 2022, "Hospice services here to see [R3]. Dressing done to heel by [Hospice] RN." -Hospice order dated November 3, 2022, "order description: unstageable pressure ulcer to the left heel. Current measures on 11/3/2022 of 1.7 cm [centimeters] X [by] 1 cm X 0 cm. Cleanse with wound cleanser, pat dry, apply barrier cream to surrounding edges of eschar tissue and then cover with 3 x 3 Optifoam, [Hospice] RN to assess 2 X [two times] weekly and change and PRN [as needed] as needed by facility staff". R3's Individualized Treatment or Therapy Management Plan dated August 4, 2022, (as referenced in R3's Service Plan Addendum) dated August 4, 2022, indicated "statement of the type of services that will be provided (check all that apply) included blood glucose monitoring Mondays and CPAP; Resident specific requirements relating to documentation and instructions of treatment and therapy received is found: treatment administration record (TAR), electronic health records (EHR/TAR)/Service charting record; Procedures for notifying a	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 134 registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy management services: a registered nurse is available 24/7 either in person or by phone for staff to report problems or concerns with treatments or therapy management services; Verification that all treatments and therapy was administered as prescribed: treatment administration record (TAR), electronic health records (EHR/TAR)/Service charting record; monitoring of treatments or therapy to prevent possible complications or adverse reactions:treatment administration record (TAR), electronic health records (EHR/TAR)/Service charting record." R3's Medication Record dated December 2022, included "freestyle lite test strip use to test blood glucose weekly on Monday" . R3's Blood Glucose sheet with dates from October 17, 2022, through December 26, 2022, identified documented blood glucose results documented weekly. R3's Care Tracking Sheet dated December 2022, identified "Oxygen Assistance Instructions AM team shut off machine, take mask off mask, remove the headgear straps, and wash out mask, nasal pillows and water chamber (humidifier) with warm soapy water. Rinse off and allow to air dry on clean towel. Staff will wash out tubing with warm water and soap once weekly on Saturday morning. PM team staff will assist resident in putting on mask for CPAP machine, staff will fill water chamber with distilled water to the "max" line and turn machine on at bedtime. When performing hourly whereabouts checks after bedtime, staff will ensure that mask is on properly and machine is on. "	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 135 R3's individualized treatment and therapy management record lacked the following: -a statement of the type of services that will be provided (wound dressing changes, heel protectors); -documentation of specific resident instructions relating to the treatments or therapy administration (wound dressing changes, heel protectors); -identification of treatment or therapy tasks that will be delegated to unlicensed personnel (wound dressing changes, heel protectors); -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services (parameters for blood glucose check (high/low readings), wound dressing changes, heal protectors, CPAP); and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions (wound dressing changes, heel protectors). On December 29, 2022, at 12:30 p.m. LALD-A and RN-B verified R3's individualized treatment and therapy management record lacked the above. LALD-A and RN-B stated they were "not aware there was verbal communication about it" from Hospice, regarding the facility staff were assisting with R3's dressing changes to left heel wound. LALD-A stated, "Our parameter standard for for blood glucose readings are above 300 and less than 60". LALD-A stated the Care Tracking Sheet indicating Oxygen Assistance Instructions was a "software issue" and they were unable to put in "CPAP" wording instead of oxygen. RN-B	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 136 stated the left heel pressure wound dressing changes and heel protectors were treatments ordered by Hospice. RN-B verified staff were not documenting for providing the services of wound dressing changes/heel protectors to R3 and R3's record lacked resident-specific requirements related to documentation of the treatments. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated the licensee's RN would specify in writing, specific instructions for each resident and document those instructions in the resident's record. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01940		
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	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 137 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 three residents (R3); had instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident and two of two unlicensed personnel (ULP-F, ULP-D) had demonstrated the ability to competently follow the procedures. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D and ULP-F's record lacked documented evidence the licensee had trained and determined ULP-D and ULP-F were competent to administer the treatment service of R1's wound care and dressing changes. ULP-F had a hire date of May 17, 2021. R1	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 138 R1 had diagnoses to include diabetes mellitus, stage four sacral pressure injury with history of osteomyelitis (an infection/inflammation in the bone), benign prostatic hyperplasia with lower urinary tract symptoms (enlarge prostate resulting in recurrent urinary tract infections, and giant cell arteritis (inflammation of the lining of the arteries, often affecting arteries in the head which can result in blindness). R1's Service Plan dated September 14, 2022, indicated R1 received services to include blood glucose checks and wound care. On December 28, 2022, at 8:15 a.m. unlicensed personnel (ULP)-F was observed to assist R1 with a blood glucose check, and wound care to R1's coccyx area (area at base of tailbone). R1's Client Treatment and Therapy Management Plan (attachment to the Service Plan) dated April 15, 2022, indicated the treatment of dressing change to coccyx, to be done twice daily with both ULP and RN management of dressing changes. R1's [licensee name] Dr. Appointment record dated November 7, 2022, indicated a Wound Clinic visit with the note "Wound clean, but deeper. Continue BID [twice daily] dressings-Use 2 x [by]2 gauze opened up and moistened with Anasept wound cleanser, petroleum to periwound, ABD [dressing] and paper tape. Follow up in six (6) weeks." R1's wound care instructions dated November 8, 2022, read, A.M. and P.M. shift to complete. 1. continue with dressing changes twice daily. 2. Gently remove old dressing. 3. Use 2 x 2 [inch]gauze opened up and moistened with Anasept wound cleaner (switched back to a	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 139 diluted Dakins solution when the Anasept wound cleaner ran out). 4. Apply petroleum around wound. 5. Cover with ABD (absorbent dressing) and affix with medipore tape (a gentle medical grade tape). R1's Wound care documentation record dated November 29, 2022-December 1, 2022, included the times of 9:00 a.m. and 5:00 p.m. as the designated times for R1's dressing changes. The ULP documented information for the following characteristics of the wound: drainage amount, drainage color, wound bed color, signs of infection, and peri area (other areas in the groin) skin integrity. On December 30, 2022, at 9:50 a.m. RN-B stated "Training is usually done with staff as R1 has had multiple wound care changes, but it's [training] probably not documented. Will do in the future." ULP-D had a hire date of August 31, 2022. ULP-D's record lacked documented evidence the licensee had trained and determined ULP-D was competent to administer the treatment service of wound dressing changes and heel protectors for R3. R3 R3's Service Plan Addendum dated August 4, 2022, indicated R3 received services which included "Treatments, including weights, vital signs daily or weekly, CPAP [continuous positive airway pressure/a machine that uses mild airway pressure to keep breathing airways open while you sleep], blood glucose checks [use of glucose meter for testing the concentration of glucose	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 140 (main sugar) in the blood], wound care, nebs, creams, insulin, etc. *Add to Med [medication]/Tx [treatment]/There [thera] plan". R3's Individualized Treatment or Therapy Management Plan dated August 4, 2022, (as referenced in R3's Service Plan Addendum) dated August 4, 2022, indicated "statement of the type of services that will be provided (check all that apply) included blood glucose monitoring Mondays and CPAP; Resident specific requirements relating to documentation and instructions of treatment and therapy received is found: treatment administration record (TAR), electronic health records (EHR/TAR)/Service charting record; Procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy management services: a registered nurse is available 24/7 either in person or by phone for staff to report problems or concerns with treatments or therapy management services; Verification that all treatments and therapy was administered as prescribed: treatment administration record (TAR), electronic health records (EHR/TAR)/Service charting record; monitoring of treatments or therapy to prevent possible complications or adverse reactions:treatment administration record (TAR), electronic health records (EHR/TAR)/Service charting record." On December 28, 2022, at 8:14 a.m. R3 was observed to have heel protectors on both feet. ULP-D stated R3 wore the heel protectors due to R3 has "sores on bottom of feet on heels". ULP-D stated R3 "kicks them off every once in a while". At 9:16 a.m., observation of R3's heels with ULP-D revealed an adhesive dressing was in place on the outer side of R3's left heel. R3's skin	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 141 was intact on right heel. ULP-D showed the evaluator a box of Optifoam gentle EX silicone faces foam and border dressings (absorbent dressing) on R3's bathroom sink countertop. ULP-D stated, "We [the ULP] put on heel". Two tubes of Thera honey gel (promotes natural debridement; removal of dead tissue from a wound) was observed on top of R3's bathroom sink countertop. ULP-D stated the night shift ULP apply the Thera honey gel and dressing to R3's heel and Hospice applied on R3's shower day. On December 28, 2022, at 12:20 p.m. RN-G stated Hospice supplied foam booties for R3 to wear on heels. RN-G stated the treatment for R3's left heel wound was "cleanse and dry the wound bed, apply Thera honey on the wound bed and apply Optifoam 3 X 3" dressing. On December 29, 2022, at 12:30 p.m. licensed assisted living director (LALD)-A and RN-B stated they were "not aware there was verbal communication about it" from Hospice, regarding the facility staff were assisting with R3's dressing changes to left heel wound. RN-B stated the left heel pressure wound dressing changes and heel protectors were treatments ordered by Hospice. RN-B verified staff were applying heel protectors to R3. RN-B verified she had not provided training and competency to ULP-D or any of the licensee's ULP for R3's left heel wound treatment. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated when the registered nurse or licensed health professional at [licensee name] delegated tasks to the unlicensed personnel, that person will ensure that prior to the delegation the unlicensed	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 142 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. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of treatments administered as required for two of three residents (R2, R3). 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	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01960	Continued From page 143 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2's record lacked the documented time of administration for the treatment service of blood glucose checks. R2's Service Plan Addendum dated August 22, 2022, indicated he received services to include medication management, blood glucose checks, catheter assistance, and insulin injections. R2's Individualized Treatment or Therapy Management Plan dated August 22, 2022, indicated the service of blood glucose monitoring with resident specific requirements relative to documentation of treatment and therapy found on the Treatment Administration Record and Electronic Records (EHR/TAR) Service Charting Record. On December 28, 2022, at 8:30 a.m. ULP-F indicated ULP provided services to include twice daily blood glucose checks, medication administration including insulin injections, urinary catheter care to include urinary bag management, and catheter site cleansing. R2's Blood Glucose record dated December 2022, indicated, "Specific Instructions: Check [R2's] blood glucose levels before breakfast and before bed. If reading is greater than 300 or less than 60, notify the RN immediately." The record indicated three columns: one for the date, one for "Before Breakfast/Staff Initials" and one for "Before Supper/Staff initials" where the ULP indicated the blood glucose number and	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01960	Continued From page 144 their initials. The record lacked the times of the day the blood glucose was checked. On December 29, 2022, at 2:45 p.m. registered nurse (RN)-B and licensed assisted living director (LALD)-A verified the records lacked the time glucose monitoring was completed and stated the RN would update the records to include this information. R3 R3's record lacked documented signature and title of the person who administered the treatment or therapy and the date and time of administration for providing the treatment services of left heel wound dressing changes and heel protectors. In addition, R3's record lacked documented time of administration for treatment service of blood glucose checks. R3's Service Plan Addendum dated August 4, 2022, indicated R3 received services which included "Treatments, including weights, vital signs daily or weekly, CPAP [continuous positive airway pressure/a machine that uses mild airway pressure to keep breathing airways open while you sleep], blood glucose checks [use of glucose meter for testing the concentration of glucose (main sugar) in the blood], wound care, nebs, creams, insulin, etc. *Add to Med [medication]/Tx [treatment]/There [thera] plan". R3's Individualized Treatment or Therapy Management Plan dated August 4, 2022, (as referenced in R3's Service Plan Addendum) dated August 4, 2022, indicated "statement of the type of services that will be provided (check all that apply) included blood glucose monitoring Mondays and CPAP; Resident specific requirements relating to documentation and instructions of treatment and therapy received is	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01960	Continued From page 145 found: treatment administration record (TAR), electronic health records (EHR/TAR)/Service charting record". R3's Medication Record dated December 2022, included "freestyle lite test strip use to test blood glucose weekly on Monday". R3's Blood Glucose sheet with dates from October 17, 2022, through December 26, 2022, identified documented blood glucose results documented weekly and included the date and results of blood glucose check. The sheet lacked time of day ULP checked R3's blood glucose. R3's Care Tracking Sheet dated December 2022, identified "Oxygen Assistance Instructions AM team shut off machine, take mask off mask, remove the headgear straps, and wash out mask, nasal pillows and water chamber (humidifier) with warm soapy water. Rinse off and allow to air dry on clean towel. Staff will wash out tubing with warm water and soap once weekly on Saturday morning. PM team staff will assist resident in putting on mask for CPAP machine, staff will fill water chamber with distilled water to the "max" line and turn machine on at bedtime. When performing hourly whereabouts checks after bedtime, staff will ensure that mask is on properly and machine is on. " R3's record identified the following information for R3's left heel pressure ulcer wound: -Notes dated August 9, 2022, R3 "has developed a blister on her left heel. Hospice is aware of it and are taking care of it." -Notes dated August 11, 2022, "Hospice services here to see [R3]. Dressing done to heel by [Hospice] RN." -Hospice order dated November 3, 2022, "order	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01960	Continued From page 146 description: unstageable pressure ulcer to the left heel. Current measures on 11/3/2022 of 1.7 cm [centimeters] X [by] 1 cm X 0 cm. Cleanse with wound cleanser, pat dry, apply barrier cream to surrounding edges of eschar tissue and then cover with 3 x 3 Optifoam, [Hospice] RN to assess 2 X [two times] weekly and change and PRN [as needed] as needed by facility staff". On December 28, 2022, at 8:14 a.m. R3 was observed to have heel protectors on both feet. ULP-D stated R3 wore the heel protectors due to R3 has "sores on bottom of feet on heels". ULP-D stated R3 "kicks them off every once in a while". At 9:16 a.m., observation of R3's heels with ULP-D revealed an adhesive dressing was in place on the outer side of R3's left heel. R3's skin was intact on right heel. ULP-D showed the evaluator a box of Optifoam gentle EX silicone faces foam and border dressings (absorbent dressing) on R3's bathroom sink countertop. ULP-D stated, "We [the ULP] put on heel". Two tubes of Thera honey gel (promotes natural debridement; removal of dead tissue from a wound) was observed on top of R3's bathroom sink countertop. ULP-D stated the night shift ULP apply the Thera honey gel and dressing to R3's heel and Hospice applied on R3's shower day. On December 28, 2022, at 12:20 p.m. Hospice RN (RN-G) stated Hospice supplied foam booties for R3 to wear on heels. RN-G stated Hospice nurse "me or LPN" (licensed practical nurse) assessed R3's wound on left heel two times a week and "PRN gets changed almost daily by the ULP [facility staff] because get's rubbed off". R3's record lacked documentation of staff providing the treatment service for left heel wound dressing changes, heel protectors and the	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
01960	Continued From page 147 time of day staff checked R3's blood glucose every Monday. On December 29, 2022, at 12:30 p.m. LALD-A and RN-B stated they were "not aware there was verbal communication about it" from Hospice, regarding the facility staff were assisting with R3's dressing changes to left heel wound. RN-B stated the left heel pressure wound dressing changes and heel protectors were treatments ordered by Hospice. RN-B verified staff were applying heel protectors to R3. RN-B verified staff were not documenting for providing the services of wound dressing changes/heel protectors to R3. LALD-A and RN-B verified R3's Blood Glucose sheet with dates from October 17, 2022, through December 26, 2022, lacked documented time of day staff checked R3's blood glucose. The licensee's Medication and Treatment Record-Documentation and Refusal policy dated August 1, 2021, indicated the following must be documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: the date, the time, the quantity of dosage, the method of administration of all prescribed legend and over the counter medications and or treatments/therapy, signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 148 electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a prescriber's order for treatment or therapy for one of three residents (R3). 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 diagnoses including Type 2 diabetes mellitus and early onset Alzheimer's dementia (progressive mental deterioration which occurs in someone under age 65). On December 28, 2022, at 8:14 a.m. R3 was observed to have heel protectors on both feet. Unlicensed personnel (ULP)-D stated R3 wore the heel protectors due to R3 has "sores on bottom of feet on heels". ULP-D stated R3 "kicks them off every once in a while". At 9:16 a.m., observation of R3's heels with ULP-D revealed an	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 149 adhesive dressing was in place on the outer side of R3's left heel. R3's skin was intact on right heel. ULP-D showed the evaluator a box of Optifoam gentle EX silicone faces foam and border dressings (absorbent dressing) on R3's bathroom sink countertop. ULP-D stated, "We [the ULP] put on heel". Two tubes of Thera honey gel (promotes natural debridement; removal of dead tissue from a wound) was observed on top of R3's bathroom sink countertop. ULP-D stated the night shift ULP apply the Thera honey gel and dressing to R3's heel and Hospice applied on R3's shower day. On December 28, 2022, at 9:20 a.m. registered nurse (RN)-B stated R3 "developed the blister to left heel after [R3] started on Hospice". R3 wore shoes prior and when the blister developed the "heel protectors" were implemented. RN-B stated the Hospice physician was notified. RN-B stated she had "measured the blister in the beginning" with the Hospice RN (RN-G). RN-B stated she "had not lately looked at" R3's wound on left heel. RN-B stated, "I have seen it, not measured it." RN-B stated, "RN-G stated Hospice would take care of the treatment for the left heel blister". On December 28, 2022, at 12:20 p.m. RN-G stated Hospice supplied foam booties for R3 to wear on heels. RN-G stated "me or LPN" (licensed practical nurse) assessed R3's wound on left heel two times a week and "PRN gets changed almost daily by the ULP [facility staff] because gets rubbed off". RN-G stated R3's wound on left heel when first noticed was "eschar bed [dead tissue that eventually sloughs off of healthy skin after an injury), Thera honey applied and sloughed off". RN-G stated R3's left heel wound was "light ulceration some sort, likely pressure, stage one [intact skin with non	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 150 blanchable redness of a localized area usually over a boney prominence]. It took eschar about one month to disappear". RN-G stated the treatment for R3's left heel wound was "cleanse and dry the wound bed, apply Thera honey on the wound bed and apply Optifoam 3 X 3" dressing. R3's Service Plan Addendum dated August 4, 2022, indicated R3 received services which included "Treatments, including weights, vital signs daily or weekly, CPAP [continuous positive airway pressure/a machine that uses mild airway pressure to keep breathing airways open while you sleep], blood glucose checks, wound care, nebs, creams, insulin, etc. *Add to Med [medication]/Tx [treatment]/There [thera] plan". R3's Individualized Treatment or Therapy Management Plan dated August 4, 2022, (as referenced in R3's Service Plan Addendum) dated August 4, 2022, indicated "statement of the type of services that will be provided (check all that apply) included blood glucose monitoring Mondays and CPAP; Resident specific requirements relating to documentation and instructions of treatment and therapy received is found: treatment administration record (TAR), electronic health records (EHR/TAR)/Service charting record". R3's service plan lacked the treatment service for left heel wound dressing change and heel protectors. R3's record identified the following information for R3's left heel pressure ulcer wound: -Notes dated August 9, 2022, R3 "has developed a blister on her left heel. Hospice is aware of it and are taking care of it." -Notes dated August 11, 2022, "Hospice services here to see [R3]. Dressing done to heel by [Hospice] RN."	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 151 R3's Care Tracking Sheet dated December 2022, identified "Oxygen Assistance Instructions AM team shut off machine, take mask off mask, remove the headgear straps, and wash out mask, nasal pillows and water chamber (humidifier) with warm soapy water. Rinse off and allow to air dry on clean towel. Staff will wash out tubing with warm water and soap once weekly on Saturday morning. PM team staff will assist resident in putting on mask for CPAP machine, staff will fill water chamber with distilled water to the "max" line and turn machine on at bedtime. When performing hourly whereabouts checks after bedtime, staff will ensure that mask is on properly and machine is on." R3's record lacked documented evidence of a prescriber orders for the treatment services of CPAP, left heel wound dressing change and heel protectors. RN-B provided surveyor with the following treatment prescription orders for R3, which were faxed to the facility on December 28, 2022 and December 29, 2022, for the following: -Fax date and time of "Dec. 28, 2022, at 9:47 a.m. Received December 28, 2022 10:56 a.m." Hospice order dated November 3, 2022, "order description: unstageable pressure ulcer to the left heel. Current measures on 11/3/2022 of 1.7 cm [centimeters] X [by] 1 cm X 0 cm. Cleanse with wound cleanser, pat dry, apply barrier cream to surrounding edges of eschar tissue and then cover with 3 x 3 Optifoam, [Hospice] RN to assess 2 X [two times] weekly and change and PRN [as needed] as needed by facility staff", with fax date and time of December 28, 2022, at 9:47	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 152 a.m. received December 28, 2022 10:56 a.m. -Fax date "12/29/2022 4:28 p.m. Received 12/29/2022 5:28 p.m." Durable Medical Equipment Prescription" dated February 21, 2022, for CPAP. On December 28, 2022, at 12:20 p.m. RN-G stated, "Yesterday, they [the licensee] asked me to send everything for orders", regarding R3's left heel wound dressing change. On December 29, 2022, at 12:30 p.m. licensed assisted living director (LALD)-A and RN-B stated they were "not aware there was verbal communication about it" from Hospice. RN-B stated the left heel pressure wound dressing changes and heel protectors were treatments ordered by Hospice. RN-B verified staff were applying heel protectors to R3. RN-B verified R3's record lacked a prescriber order for wound dressing change to R3's left heel and for heel protectors. RN-B stated they would look for an order for R3's CPAP. On December 30, 2022, at 9:20 a.m. RN-B provided R3's CPAP prescriber order and stated, "Yesterday I called [R3's] physician and they did not have it, so I called the sleep center to get the order". The licensee's Medication and Treatment Orders policy dated August 1, 2021, indicated the 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. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
02110	Continued From page 153	02110		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
02110	Continued From page 154 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and designated representatives at the time of move in for three of three residents (R1, R2, R3). 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 was admitted to the licensee for assisted living services on November 23, 2021. R2 was admitted to the licensee for assisted living services on August 12, 2021. R3 was admitted to the licensee June 7, 2021, and started receiving assisted living services August 1, 2021. R1, R2 and R3's resident records lacked documented evidence the residents and the residents' legal and designated representatives received the written policies and procedures that addressed 144G.82 Subd. 3. at the time of move-in to the facility. The licensee's residents Service Plan Addendum utilized, included signature for receipt on "page 7"	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
02110	Continued From page 155 for receipt of information for: "I have been offered a copy of the Disclosure of Special Care Unit, which includes dementia training information". Review of the licensee's [licensee name] Disclosure of Special Care Unit information sheets undated, included information for "disclosure, philosophy, criteria for residence in [licensee name] memory care, process used for the assessment and establishment of the service plan, [licensee name] staffing credentials and training, special care unit design and security features, programs and activities for residents of the special care unit, our activity program, our wellness program family involvement, fee schedules for additional services to memory care residents". The content of the licensee's [licensee name] Disclosure of Special Care Unit information sheets did not include the licensee's assisted living facility with dementia care policy and procedures as listed below, or specifically reference the policies as being provided to the resident and the residents' legal and designated representatives: -3.02 ALDC Behavioral Symptoms, Interventions and Nonpharmalogical Approaches dated August 1, 2021; -3.03 ALDC Dementia Care Philosophy dated August 1, 2021; -3.04 ALDC Family Support dated August 1, 2021; -3.05 ALDC Life Enrichment Programs, Activities and Outdoor space dated August 1, 2021; -3.07 ALDC Medication Management dated August 1, 2021; -3.08 ALDC Notice of Dementia Training dated August 1, 2021; -3.10 ALDC Safekeeping of Resident	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
02110	Continued From page 156 Possessions dated August 1, 2021; -3.11 ALDC Transportation Coordination dated August 1, 2021; -3.12 ALDC Use of Intercom dated August 1, 2021; -3.13 ALDC Wandering and Elopement dated August 1, 2021 On December 29, 2022, at 12:30 p.m. license assisted living director (LALD)-A stated the residents signed for receiving the "disclosure of care unit", which included dementia training information as part of information received when service plans were signed. LALD-A stated, "I would have to double check" regarding if the "disclosure" included the policies and procedures required to be given to residents and the residents' legal and designated representatives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by:	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
02140	Continued From page 157 Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 27, 2022, at 11:13 a.m. licensed assisted living director (LALD)-A stated she oversaw training staff in the care of individuals with dementia. On December 30, 2022, at 9:20 a.m. LALD-A stated, "I don't think I have a separate test for training" referring to completion of successfully passing a skills competency or knowledge test required by the commissioner as required. LALD-A stated she only had the "basic training everyone does" for dementia. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
02170	Continued From page 158 according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure evaluation for activities and an individualized activity plan	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
02170	Continued From page 159 was developed for one of three residents (R3). 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 diagnoses included early onset Alzheimer's dementia (progressive mental deterioration which occurs in someone under age 65). R3's Service Plan Addendum dated August 4, 2022, included "activities escort daily and as needed". R3's assessment for change of condition dated August 4, 2022, included "indicate any assistance needed to support orientation behaviors" was "C. Frequently needs redirection: moderate disorientation to person, place, or time"; "indicate conditions that affect the resident's responsive behaviors within the last year" was "B. Anxiety disorder, G. Dementia"; "indicate any assistance needed to support identified conditions/diagnoses that impact resident's responsive behaviors " was "staff reminded in care plan of need for behavior monitoring". R3's Care Tracking Sheet dated December 2022, identified "escort resident to activities of interest". On December 28, 2022, at 7:58 a.m. R3 was observed seated in a Broda chair (a positioning	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
02170	Continued From page 160 wheelchair) in the living room area watching television. At 8:14 a.m., unlicensed personnel (ULP)-D was observed to administer medications to R3 and gave R3 a baby doll to hold. ULP-D stated R3 liked music and liked to sing along, coloring, would attend music events in main lobby of facility and sometimes staff would read a book to R3. R3's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R3's record lacked an individualized activity plan developed based on an activity evaluation, which reflected the R3's activity preferences and needs, including a selection of daily structured and non-structured activities being provided and included on the resident's activity service or care plan as appropriate. On December 29, 2022, at 12:30 p.m. licensed assisted living director (LALD)-A stated, "We are currently working on with consultant, it is still in process" regarding R3 lacked an evaluation for activities and an individualized activity plan. The licensee's 3.05 ALDC Life Enrichment Programs, Activities and Outdoor Space policy dated August 1, 2021, indicated as an assisted living with dementia care licensed facility the	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
02170	Continued From page 161 licensee strived to provide valuable activities and life enrichment programs for resident's with Alzheimer's diseases or other dementia's. "Activities and life enrichment programs are implemented in the following manner: [the licensee] offers a daily activity program which incorporates both group and individual activities focusing on self care, leisure, life-enriching activities and productive and useful activities. 3. An individual activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. 4. A selection of daily and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02180 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Access to secured outdoor space and walkways that allow residents to enter and return without staff assistance must be provided. This MN Requirement is not met as evidenced	02180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
02180	Continued From page 162 by: Based on observation, interview, and record review, the licensee failed to ensure behavioral symptoms were identified and were addressed on the care plan for one of three residents (R3). 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 diagnoses included early onset Alzheimer's dementia (progressive mental deterioration which occurs in someone under age 65). R3's Service Plan Addendum dated August 4, 2022, included the service of behavior monitoring or intervention daily as needed. R3's assessment for change of condition dated August 4, 2022, included "indicate any assistance needed to support orientation behaviors" was "C. Frequently needs redirection: moderate disorientation to person, place, or time"; "indicate conditions that affect the resident's responsive behaviors within the last year" was "B. Anxiety disorder, G. Dementia"; "indicate any assistance needed to support identified conditions/diagnoses that impact resident's responsive behaviors " was "staff reminded in care plan of need for behavior monitoring". On December 28, 2022, at 8:14 a.m. ULP-D was	02180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
02180	Continued From page 163 observed to administer medications to R3. ULP-D crushed a total of nine medications and placed the medications in applesauce prior to administering the medications to R3. The medications observed to be crushed were vitamin B12 (used to treat deficiency) 1,000 micrograms (mcg) two tablets; vitamin D3 5,000 international units (IU) (used for supplement), memantine 5 milligrams (mg) (used to treat Alzheimer's disease), buspirone 10 mg (used for anxiety), aripiprazole 5 mg one half tablet (used for depression), bupropion 100 mg (used for depression), hydromorphone 2 mg one half tablet (used for back pain), and metformin 500 mg (used to treat diabetes). R3's Medication Record for December 2022, included buspirone 10 mg take one tablet twice daily, aripiprazole 5 mg take one half tablet twice daily and bupropion 100 mg take one tablet three times a day for depression. R3's Care Tracking Sheet dated December 2022, identified "behavior intervention instructions: R3 has moments of forgetfulness. She may not remember that she asked for something. Staff will need to assist in reassuring and redirecting her at all times wen she is confused. According to family members, she may fabricate information at times or believe that she has done something when she hasn't. She has at times become more confused in the evenings and won't understand why she is here. Please reassure and redirect. R3's service plan/Care Tracking Sheet lacked specific behaviors/symptoms for depression and non-pharmalogical interventions to implement for behavioral symptoms of depression; lacked specific non-pharmalogical interventions to implement for reassuring and redirecting for when	02180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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
02180	Continued From page 164 R3 may fabricate information at times or believe that she has done something when hasn't and when becomes more confused in the evenings that negatively impact the resident and others and lacked monitoring of specific behaviors/symptoms for depression and anxiety for the use of aripiprazole, bupropion and buspirone medications. On December 29, 2022, at 12:30 p.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B stated, "okay" regarding R3's record lacked the above. RN-B stated, "We don't identify symptoms or monitor". The licensee's policy 3.02 ALDC Behavioral Symptoms, Interventions and Nonpharmalogical Approaches dated August 1, 2021, indicated the licensee supports person-centered and evidence based evaluation of behavioral symptoms and design of supports for intervention plans; including nonpharmalogical interventions and practices in the following ways: the licensee would identify behavioral symptoms that negatively impact other residents and other in the assisted living facility and evaluate to determine potential interventions to minimize such behaviors. Interventions should be identified on the care plan or service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02180		

DEPARTMENT OF HEALTH

Type: Full
Date: *12/27/22*
Time: 10:04:43
Report: 7920221271

Food and Beverage Establishment Inspection Report

Location:
Claddagh Senior Living Llc
508 Kruckow Avenue North
Caledonia, MN55921
Houston County, 28

Establishment Info:
ID #: 0038236
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5077255200
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 181 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Third sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 200 Degrees Fahrenheit - Location: Taco meat
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -15 Degrees Fahrenheit - Location: Vegetables, breakfast food
Violation Issued: No

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

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

Process/Item: Upright Freezer
Temperature: -10 Degrees Fahrenheit - Location:
Violation Issued: No

Food and Beverage Establishment Inspection Report

They have applied for the State Certified Food Protection Manager Certificate.

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 7920221271 of 12/27/22.

Certified Food Protection Manager: Jennifer Schellhas

Certification Number: ss 8/10/22 Expires: / /

Signed: _____
Establishment Representative

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