

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,

ods John

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

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Protecting, Maintaining and Improving the Health of All Minnesotans

**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.

Claddagh Senior Living February 3, 2023 Page 2

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 <u>email</u> general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Claddagh Senior Living February 3, 2023 Page 3

> 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. <u>Please note that you</u> <u>may request a reconsideration **or** a hearing, but not both</u>.

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

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		33458	B. WING		12/30/2022	
	ROVIDER OR SUPPLIER	508 KRU	DRESS, CITY, CKOW AVEN NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	
0 000	Initial Comments		0 000			
	CORRECTION OR In accordance with 144G.08 to 144G.9 issued pursuant to Determination of wirequires compliance provided at the Stat When Minnesota S failure to comply wir considered lack of or INITIAL COMMENT SL#33458015 On, December 27, 2022, the Minnesot conducted a survey the following correct time of the survey, for	PROVIDER LICENSING DER(S) Minnesota Statutes, section 95, these correction orders are a survey. Thether violations are corrected e with all requirements tute number indicated below. tatute contains several items, th any of the items will be compliance. TS: 2022, through December 30, a Department of Health of at the above provider, and tion orders are issued. At the there were 37 active residents; es under the Assisted Living		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living License Providers. The ass tag number appears in the far left of entitled "ID Prefix Tag." The state S number and the corresponding tex state Statute out of compliance is I the "Summary Statement of Deficie column. This column also includes findings which are in violation of th requirement after the statement, "T Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Corr PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES T FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA ST STATUTES.	ftware. to ted igned column Statute t of the isted in encies" the e state This as eyors' rection. DING OF O THIS	
0 110 SS=F	license required	on 1a Assisted living director	0 110			
	assisted living direct	g facility must employ an stor licensed or permitted by tives for Long Term Services				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	GH SENIOR LIVING	508 KRU	CKOW AVENU	JE NORTH		
CLADDA	IGH SENIOR LIVING	CALEDO	NIA, MN 5592	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
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	This MN Requirement by: Based on observation review, the licenseed assisted living direct Director of Record potential to affect a staff, and visitors. This practice result violation that did no safety but had the president's health or widespread scope of or represent a syste or has the potential the residents). The findings include On December 27, 22 Minnesota Board of Services and Supprindicated LALD-A c effective through O LALD-A's license lat the Director of Record On December 27, 22 evaluator emailed a clarify LALD-A's stat the facility. At 1:43 representative resp her Director of Record several times over renewals since July	ent is not met as evidenced ion, interview and record e failed to ensure licensed ctor (LALD)-A was listed as the for the licensee. This had the ll the licensee's residents, ed in a level two violation (a tharm a resident's health or botential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all e: 2022, at 1:00 p.m. the f Executives for Long-Term ort (BELTSS) website urrently held a LALD license ctober 31, 2022; however, acked an organization listed as ord for the licensee. 2022, at 1:36 p.m. the a BELTSS representative to atus as director of record for				
		n record for this location. She TSS, if she does not know				
nesota D	assisted living direct Director of Record potential to affect a staff, and visitors. This practice result violation that did no safety but had the p resident's health or widespread scope of or represent a syste or has the potential the residents). The findings include On December 27, 2 Minnesota Board of Services and Supprindicated LALD-A c effective through O LALD-A's license la the Director of Record On December 27, 2 evaluator emailed a clarify LALD-A's stat the facility. At 1:43 representative resp her Director of Record instructions have bo several times over renewals since July check and that locat is no other LALD or	ctor (LALD)-A was listed as the for the licensee. This had the ll the licensee's residents, ed in a level two violation (a th harm a resident's health or botential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all e: 2022, at 1:00 p.m. the f Executives for Long-Term ort (BELTSS) website urrently held a LALD license ctober 31, 2022; however, acked an organization listed as ord for the licensee. 2022, at 1:36 p.m. the a BELTSS representative to atus as director of record for p.m., the BELTSS bonded "She has not updated ord for any location. Those een sent out to the LALD the course of the license (2022-October 21, 2022. I did ation is in our database. There				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED	
		33458	B. WING		12/	30/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		ICKOW AVENU INIA, MN 5592			
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	how to update her l	icense portal."				
	stated she thought to BELTSS and did contact from BELTS requirements. LALE	2022, at 2:15 p.m. LALD-A she had turned everything in not recall receiving email SS with additional D-A stated she would t the representative from				
	No further informati	on was provided.				
	TIME PERIOD FOF days	R CORRECTION: Two (2)				
0 250 SS=F	144G.20 Subdivisio	n 1 Conditions	0 250			
	provisional license, result of a change in a license, suspend a conditional license individual, or emplo facility: (1) is in violation of, license has violated this chapter or adop (2) permits, aids, or illegal act in the pro services; (3) performs any ac safety, and welfare (4) obtains the licen misrepresentation; (5) knowingly make material fact in the	abets the commission of any vision of assisted living at detrimental to the health, of a resident;	3			

STATE FORM

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
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	SH SENIOR LIVING	CALEDO	NIA, MN 5592	21		
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	files, or employees; (7) interferes with o the department in c residents; (8) interferes with o access according to subdivision 4; (9) interferes with o the department in th or fails to fully coop survey, or investiga (10) destroys or ma or other evidence re facility's compliance (11) refuses to initia section 144.057 or (12) fails to timely p commissioner; (13) violates any loo relating to housing o (14) has repeated in performing services level; or (15) has operated b assisted living facili (b) A violation by a assisted living servi by the facility. This MN Requirement by: Based on interview licensee failed to sh of licensure, by atte who oversaw the da understood applicated developed and/or in	r impedes a representative of ontacting the facility's r impedes ombudsman o section 256.9742, r impedes a representative of he enforcement of this chapter erate with an inspection, tion by the department; tikes unavailable any records elating to the assisted living e with this chapter; ate a background study under				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
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	residents, staff, and	d visitors.				
	violation that did no safety but had the resident's health or cause serious injur is issued at a wides are pervasive or re	ted in a level two violation (a ot harm a resident's health or potential to have harmed a r safety, but was not likely to y, impairment, or death), and spread scope (when problems present a systemic failure that a the potential to affect a large residents).				
	The findings includ	e:				
	2022, at 11:00 a.m director (LALD)-A s employees in charg with the assisted liv	e conference on December 27, ., licensed assisted living stated the licensee's ge of the facility were familiar ving regulations and the medication and treatment ces.				
	License, section tit Owner or Authorize the application), ide	lication for Assisted Living led Official Verification of ed Agent, (page four and five of entified, I certify I have read e following: [a check mark was n of the following]:				
	[Minnesota] Stat. [s 144G.45, my buildi subdivisions 1-3 of section Laws 2020	ully understand Minn. statute] sect. [section] ng(s) must comply with the section, as applicable , 7th Spec. [special] Sess napter] 1. art. [article] 6, sect.				
	sect. 144G.80, 144	ully understand Minn. Stat. G.81. and Laws 2020, 7th 1, art. 6, sect. 22, my				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
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	building(s) must co applicable.	mply with these sections if				
	- Assisted Living Lic chpt. 144G.	censure statutes in Minn. Stat.				
	- Assisted Living Lie Rules, chpt. 4659.	censure rules in Minnesota				
	- Reporting of Maltr	eatment of Vulnerable Adults.				
	- Electronic Monitor	ing in Certain Facilities.				
	Rights of Subjects of use information pro- may include an in-p- conference, to deter requirements for as understand I am no- requested information information or the s- misleading information of my application of a license. I understate to the commissioner some circumstance appropriate state, for enforcement office enforcement efforts protective process. Types of of Services, offices of health-licensing boo	rmine if the applicant meets sisted living licensing. I be legally required to supply the ion; however, failure to provide submission of false or tion may delay the processing r may be grounds for denying and that information submitted er in this application may, in tes, be disclosed to the ederal or local agency and law to enhance investigative or s or further a public health				
	local or county publ - I understand in ac sect. 144.051 Data					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
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	classified as public a provisional licens	his application shall be information upon issuance of e or license. All data submitted ate until MDH issues a				
	I attest that I have r and Minnesota Rule the provision of ass understand as the I responsible for the operation of the fac	the owner or authorized agent, read Minn. Stat. chapter 144G, es, chapter 4659 governing sisted living facilities, and licensee I am legally management, control, and sility, regardless of the agement agreement or				
	attachments and ch indicating my review Minnesota Statutes related to assisted my knowledge and true, correct, and co	this application and all necked the above boxes w and understanding of s, Rules, and requirements living licensure. To the best of believe, this information is omplete. I will notify MDH, in tiges to this information as				
	procedures of Minn Minn. Rules chapte	required policies and 1. Stat. chapter 144G and 1. 4659 in place upon licensure current as applicable.				
	Page five was elect May 26, 2022.	tronically signed by LALD-A on				
		n assisted living license issued with an expiration date of				
		to ensure the following lures were developed and/or				

ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
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	evaluations of staff staff performance; - conducting initial a evaluations and as including assessme appropriate license changes in a reside identified, managed and other health ca - infection control p - conducting approp documentation of p staff are free of tub	d, and communicated to staff ire providers as appropriate;				
	<ul> <li>delegation of task licensed health pro</li> <li>supervision of unl delegated tasks.</li> <li>As a result of this s were issued 0510,</li> </ul>	eatment management; s by registered nurses or fessionals; icensed personnel performing urvey, the following orders 0660, 1370, 1380, 1420, 1440	3			
	1890, 1940, 1950, indicating the licens Minnesota statutes	1710, 1730, 1760, 1790, 1880 1960, 1970, and 2140 see's understanding of the were limited, or not evident fo nnesota Statutes, section 5.				
		ion was provided. R CORRECTION: Twenty-one				
0 470	(21) days 144G.41 Subdivisio	n 1 Minimum requirements	0 470			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		33458	B. WING		12/	12/30/2022	
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di (i) lest (ii) thun by oi (ii) a si (ii) fa a (iii) fa a (iii) fa a (iii) fa a (iii) fa a (iii) fa a (iii) fa a (iii) fa a (iii) fa a (iii) fa a (iii) fa a (iii) fa a (iii) fa a) fa (iii) (ii) (iii) fa (ii)) (ii) (ii) (ii) (ii) (ii)) (ii) (ii)) (ii) (ii))	etermining its staff ) includes an evalu- east twice a year, of taffing levels in the i) ensures sufficient the scheduled and in the scheduled needs y the residents' as n a 24-hour per da ii) ensures that the nd effectively to in nd to emergency, ituations affecting (2) ensure that one vailable 24 hours per vailable 26 hours per vailable 27 hours per vailable 28 hours per vailable 29 hours per vailable 20 hours per vailable 20 hours per vailable 20 hours per vailable 26 hours per vailable 27 hours per vailable 28 hours per vailable 29 hours per vailable 20 hours per vailable 20 hours per vailable 28 hours per vailable 29 hours per vailable 20 hours per	uation, to be conducted at of the appropriateness of a facility; In staffing at all times to meet reasonably foreseeable of each resident as required sessments and service plans ay basis; and a facility can respond promptly dividual resident emergencies life safety, and disaster staff or residents in the facility e or more persons are ber day, seven days per week, a for responding to the ts for assistance with health of persons must be: Ime building, in an attached ntiguous campus with the espond within a reasonable municating with residents; iding or summoning the nce; and ving directions; ent is not met as evidenced on, interview, and record a failed to ensure the 24-hour as posted with all required staffing plan was developed to evels to meet the needs of all the potential to affect all	;				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	•	
	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
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0 470	violation that did no safety but had the p resident's health or cause serious injur was issued at a wid problems are perva- failure that has affe a large portion or a The findings include The licensee held a facility license, and census of 37 reside STAFFING SCHED On December 27, 2 posted staff schedu bulletin board locat desk in the main lo "A.M. staff 3 Aides, [night] staff 2 Aides 24 hrs [hours]". On December 27, 2 assisted living direct posted staff schedu stated the posting v schedule". LALD-A include all required can fix that." LALD-A	ot harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic octed or has potential to affect ll of the residents). e: an assisted living dementia at the time of the survey had a ents. DULE 2022, at 10:52 a.m. the facility ule was observed posted on a ed on a wall near the front bby. The posting included P.M. staff 3 Aides, NOC c, RN [registered nurse] on call 2022, at 12:40 p.m. licensed ctor (LALD)-A observed the ule with the evaluator and was the facility's "posted staff A verified the posting did not content. LALD-A stated, "We A stated, "We don't have it ory care unit [locked unit], now at."		DEFICIENC		

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 470	Continued From pa	ge 10	0 470			
	or work location; an -be posted after rec member's resident of each work shift in building STAFFING PLAN The licensee failed staffing plan for det -includes an evalua twice a year, of the levels in the facility; -ensured sufficient scheduled and reas unscheduled needs by the residents' as on a 24-hour per da -ensured that the fa and effectively to in and to emergency, situations affecting -ensured that one of 24 hours per day, s responsible for resp residents for assista needs. Such person (i) awake; (ii) located in the sa building, or on a co facility in order to re amount of time; (iii) capable of comm (iv) capable of follow	lacting direct-care staff assignments, at the beginning in a central location in each to develop and implement a ermining its staffing level that: tion, to be conducted at least appropriateness of staffing staffing at all times to meet the conably foreseeable of each resident as required sessments and service plans ay basis; and ucility can respond promptly dividual resident emergencies life safety, and disaster staff or residents in the facility or more persons are available even days per week, who are bonding to the requests of ance with health or safety ns must be: ume building, in an attached ntiguous campus with the espond within a reasonable municating with residents; iding or summoning the nce; and ving directions;				
	stated "the RN revie	2022, at 10:20 a.m. LALD-A ews and approves the have a written staffing plan".				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		ICKOW AVENU INIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	ION SHOULD BE	(X5) COMPLET DATE
TAG			IAG	DEFICIENC		
0 470	Continued From pa	ge 11	0 470			
	No further informati	on was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
0 485 SS=C	144G.41 Subd 1. (1 Requirements	3) (i) (A) and (C) Minimum	0 485			
	(13) offer to provide following services to	or make available at least the presidents:	e			
	available seven day recommended dieta States Department	ritious meals daily with snacks ys per week, according to the ary allowances in the United of Agriculture (USDA) g seasonal fresh fruit and he following apply:	5			
	advance, and made facility must encour menu planning. Mea similar nutritional va	prepared at least one week in a available to all residents. The age residents' involvement in al substitutions must be of alue if a resident refuses a Residents must be informed u changes;				
	(C) the facility cann and pay for meals in	ot require a resident to include n their contract;	•			
	by: Based on interview, licensee failed to er meals daily accordin dietary allowances i	ent is not met as evidenced and record review, the nsure at least three nutritious ng to the recommended in the United States culture (USDA) guidelines.				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 485	Continued From pa	age 12	0 485			
	violation that has no a minimal impact of affect health or safe widespread scope or represent a syste or has potential to a the residents). The findings include The licensee's men December 26, 2022 lacked evidence of and dairy to be inclu	ed in a level one violation (a o potential to cause more than n the resident and does not ety) and was issued at a (when problems are pervasive emic failure that has affected affect a large portion or all of e: nu provided for the dates of 2, through January 1, 2023, fruit for "lunch" meals listed uded on the menu to meet the s required. No beverages were				
	manager (HM)-C si food protection man reviewed the menu the information liste know they serve dr	2022, at 10:37 a.m. housing tated she was the certified nager for the facility. HM-C with the evaluator and verified ed above. HM-C stated, "I inks" with meals, which •C stated herself and the "cook				
	policy dated August licensee would offe available three mea seven days per wee recommended dieta	d Service and Menu Planning t 9, 2021, indicated the er to provide and make als daily with snacks available ek according tot he ary allowances in the USDA g seasonal fresh fruit and				
	No further informat	ion was provided.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-One	•			

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/30/2022		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	T ADDRESS, CITY, STATE, ZIP CODE				
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
0 510 SS=D	144G.41 Subd. 3 Ir	fection control program	0 510				
	maintain an infection complies with accer- nursing standards f (b)The facility's infe- consistent with curr- national Centers for Prevention (CDC) fr control in long-term- applicable, for infec- assisted living facili (c) The facility must compliance with thi This MN Requireme- by: Based on observation review, the licensee maintain an effective that complies with a and nursing standar to glove use and har	ection control program must be rent guidelines from the r Disease Control and or infection prevention and care facilities and, as etion prevention and control in ties. t maintain written evidence of s subdivision. ent is not met as evidenced ion, interview, and record e failed to establish and ve infection control program accepted health care, medical rds for infection control related andwashing during treatment					
	residents (R8). This practice result violation that did no safety but had the p resident's health or isolated scope (whe residents are affect	ninistration for one of four ed in a level two violation (a ot harm a resident's health or potential to have harmed a safety) and was issued at an en one or a limited number of red or one or a limited number d, or the situation has occurred					
	The findings include	e:					
	The licensee failed	to ensure gloves were worn					

STATE FORM

T OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
	33458	B. WING		12/30/2022		
ROVIDER OR SUPPLIER						
GH SENIOR LIVING						
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
Continued From pa	age 14	0 510				
personnel (ULP)-F oral medications ar spray to R8 without	was observed to administer nd then administered nasal t glove use and proceeded					
stated she expecte administration of na drops. She expecte between nasal mee hand washing and	d gloves to be worn with the asal medications and eye ed ULP to remove gloves in dication administration with clean gloves donned prior to					
2021, indicated glo there may be direct	ves must be worn whenever t contact between and					
1, 2022, indicated h performed by all en between tasks and when conducting a gloves, proper hand	nand washing would be nployees as necessary, procedures. Additionally, procedure requiring the use o d hygiene should be completed	f				
TIME PERIOD FOI days	R CORRECTION: Seven (7)					
	ROVIDER OR SUPPLIER GH SENIOR LIVING SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From para and proper handwar between the admin and eye drops. On December 28, 3 personnel (ULP)-F oral medications ar spray to R8 without without handwashing R8's eye drops. On December 28, stated she expecter administration of marks drops. She expecter administration of marks between nasal medications or December 28, stated she expecter administration of marks drops. She expecter administration of The licensee's Glove 2021, indicated glove there may be direct employee and containstructed. The licensee's Ham 1, 2022, indicated H performed by all er between tasks and when conducting a gloves, proper ham before donning and TIME PERIOD FOR	33458         STREET A         GH SENIOR LIVING         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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 o gloves, proper hand hygiene should be completed before donning and after removing gloves.         No other information was provided.         TIME PERIOD FOR CORRECTION: Seven (7)	A BUILDING:	A BUILDING:       A BUILDING:       STREET ADDRESS, CITY, STATE, ZIP CODE       SOUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)       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 ULP to remove gloves in between 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 proceedure 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)	Image: state in the image: st	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	•	
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
0 550	Continued From pa	ge 15	0 550			
	144G.41 Subd. 7 R maltreatment	esident grievances; reporting	0 550			
	procedure, and the e-mail contact infor- are responsible for The notice must als information for the s Office of Ombudsm the Office of Ombudsm the Office of Ombudsm the Office of Ombudsm the Office of Ombudsm Developmental Disa information for repor- to the Minnesota Ac This MN Requirement by: Based on observation review, the licenseed related to the grieva	ne facilities' grievance name, telephone number, and mation for the individuals who handling resident grievances. so have the contact state and applicable regional nan for Long-Term Care and dsman for Mental Health and abilities, and must have orting suspected maltreatment dult Abuse Reporting Center. ent is not met as evidenced on, interview, and record e failed to post information ance procedure. This had the Il residents, staff, and visitors.				
	violation that did no safety but had the p resident's health or cause serious injury was issued at a wid problems are perva	ed in a level two violation (a t harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and lespread scope (when sive or represent a systemic cted or has potential to affect I of the residents).				
	The findings include	9:				
	location and a discl include: -the e-mail contact	d postings in a conspicuous osure of resident advocacy to information for the individuals e for handling resident				

	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		ICKOW AVENU INIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 550	Continued From pa	ge 16	0 550			
	grievances; and -the contact informa Ombudsman for Me Developmental Disa					
	assisted living direct facility posted griev evaluator and verified	2022, at 12:40 p.m. licensed ctor (LALD)-A observed the ance information with the ed the posting did not include t listed above. LALD-A stated	,			
	No further informati	on was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
0 630 SS=D	144G.42 Subd. 6 (b requirements for re		0 630			
	individual abuse provulnerable adult. The individualized review person's susceptible individual, including person's risk of abu- and statements of the taken to minimize the	t develop and implement an evention plan for each ne plan shall contain an w or assessment of the lity to abuse by another other vulnerable adults; the using other vulnerable adults; he specific measures to be ne risk of abuse to that person e adults. For purposes of the lan, abuse includes				
	by: Based on interview failed to ensure dev	ent is not met as evidenced and record review, the facility velopment of an individual lan with the required content idents (R1).				

STATEMEN	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		33458	B. WING		12/30/2022		
NAME OF I	PROVIDER OR SUPPLIER	•	ADDRESS, CITY, STATE, ZIP CODE				
CLADDA	GH SENIOR LIVING	508 KRU	ICKOW AVENU DNIA, MN 5592	JE NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
0 630	Continued From pa	age 17	0 630				
	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 includ	e:					
	indicated R1 receiv	dated September 14, 2022, red services to include stration, blood glucose checks, illy safety checks.					
	dated September 9 in the section ident to abuse from anot vulnerable adults?" entered into the col Additionally, the do	ion or goal regarding R1's	•				
	assisted living direct IAPP lacked the ind abuse by others. La susceptible to abuse	2022, at 2:30 p.m. licensed ctor (LALD)-A confirmed R1's dication he was susceptible to ALD-A stated all residents are se by others. LALD-A stated he information to correct it.					
	prevention and rep 2021, indicated the individualized vulne plans to identify vul	nerable adult Maltreatment orting policy dated August 1, licensee developed erable adult abuse prevention nerability risks and develop nize maltreatment based on					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	GH SENIOR LIVING		ICKOW AVENU INIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 630	Continued From pa	ge 18	0 630			
	identified informatio	n.				
	No further informati	on was provided.				
	TIME PERIOD FOF days	R CORRECTION: Seven (7)				
0 640 SS=F	144G.42 Subd. 7 P reporting suspected	osting information for I c	0 640			
	through access to t reporting suspected suspected vulnerab (1) posting the 911 common areas and the assisted living f (2) posting informat for the Minnesota A to report suspected adult under section (3) providing reason	tion and the reporting number dult Abuse Reporting Center maltreatment of a vulnerable				
	by: Based on observati failed to support pro posting information reporting to the Min Center (MAARC) ar emergency number telephones provided	ent is not met as evidenced on and interview, the licensee otection and safety by not and phone numbers for nesota Adult Abuse Reporting nd failed to post the 911 in common areas and near d by the assisted living facility. ial to affect all 37 residents,				
	violation that did no	ed in a level two violation (a t harm a resident's health or potential to have harmed a				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING	B. WING		30/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
0 640	resident's health or cause serious injur was issued at a wid problems are perva failure that has affe a large portion or a The findings include On December 28, 2 observation of the f living director (LALI MAARC information the main lobby des or the required MAA common areas. LA place" the information	safety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic octed or has potential to affect II of the residents). e: 2022, at 10:19 a.m. facility with licensed assisted D)-A identified posted 911 and n located by a phone behind k. No 911 emergency number ARC information was posted in LD-A stated "yes, the only ion was posted in the facility phone behind the main lobby	0 640			
0 660 SS=D	(21) days	R CORRECTION: Twenty-one uberculosis prevention and	0 660			
	(a) The facility must comprehensive tub program according tuberculosis infection the United States C and Prevention (CE Elimination, as pub and Mortality Week include a tuberculor covers all paid and	st establish and maintain a erculosis infection control to the most current on control guidelines issued by Centers for Disease Control DC), Division of Tuberculosis lished in the CDC's Morbidity ty Report. The program must sis infection control plan that unpaid employees, ts, and regularly scheduled				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
0 660	Continued From pa	ge 20	0 660			
	technical assistance the guidelines.	nmissioner shall provide e regarding implementation of st maintain written evidence of s 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).					
	violation that did no safety but had the p resident's health or cause serious injury was issued at an is limited number of re a limited number of	ed in a level two violation (a tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				
	The findings include	e:				
		acility risk assessment dated licated they were a low risk.				
	ULP-F's personnel May 17, 2021.	file identified she was hired on				
	two step TST skin t 2021, and June 11,	file included a record of her ests completed on May 20, 2021, which were both n December 29, 2022, at 8:45				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
0 660	Continued From pa	age 21	0 660			
	evaluator with ULP December 29, 2022 evidence a TB sym	iger (HM)-C provided the -F's TB Screening Tool dated 2. The personnel file had no ptom screening was n 90 days prior to the hire				
	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.					
	dated August 1, 20 screening, "Staff wi require work within clients will be scree tuberculosis prior to clients. Baseline (u completed, but seri be required with ind exposure." Screening would be 1. New staff will b TB using the Basel	erculosis Screening policy 21, indicated for staff hose essential job functions the same air space of care ened and tested for the staff being exposed to pon hire) screening will be al (annual) screening will only creased occupational risk or e conducted as follows: e screened for active signs of ine TB Screening Tool for				
	<ul> <li>two-step Mantoux of documented on the for HCWs.</li> <li>3. No staff will be the work involves s residents until the r Mantoux are read a IGRA blood test reseand documer</li> <li>4. Staff TB screen</li> </ul>	nted. ning results will be kept in each				
nnesota D	employee medical 5. Staff should be symptoms on an ar epartment of Health	screened for signs and				

STATE FORM

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE	•	
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 660	Continued From pa	ge 22	0 660			
	guidelines, Regulat in Minnesota Health 2013, and based or employee may beginegative TB history symptoms of active IGRA (serum blood within 90 days befo be performed after starts working with	partment of Health (MDH) ions for Tuberculosis Control in Care Settings, dated July in CDC guidelines, indicated an in working with patients after a and symptom screen (no TB disease) and a negative test) or TST (first step) dated re hire. The second TST may the HCW (health care worker) patients. Baseline TB e documented in the				
	dated August 1, 202 screening: Staff wh require work within clients will be scree tuberculosis prior to	erculosis Screening Policy 21, indicated for staff ose essential job functions the same air space of care aned and tested for the staff being exposed to pon hire) screening will be				
	No further informati	on was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
0 680 SS=F	144G.42 Subd. 10 l emergency prepare	Disaster planning and dness	0 680			
	contains a plan for elements of shelter	t meet the following mergency disaster plan that evacuation, addresses ing in place, identifies n sites, and details staff				

Minnesota Department of Health STATE FORM

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	D <u>ta Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
0 680	Continued From pa	ge 23	0 680			
	emergency; (2) post an emerge (3) provide building all residents; (4) post emergency and (5) have a written p missing tenant resid (b) The facility musi disaster training to orientation and ann make emergency a available to all resid received emergenc allowed to work onl working on site. (c) The facility musi requirements adopt This MN Requirements by: Based on observati review, the licensee exit diagrams were had the potential to and any visitors. This practice result violation that did no safety but had the p resident's health or cause serious injury was issued at a wid problems are perval	t provide emergency and all staff during the initial staff ually thereafter and must nd disaster training annually dents. Staff who have not y and disaster training are y when trained staff are also t meet any additional ted in rule. ent is not met as evidenced on, interview, and record e failed to ensure emergency posted on each floor. This affect all 37 residents, staff ed in a level two violation (a t harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and lespread scope (when isive or represent a systemic cted or has potential to affect ll of the residents).				

Minnesc	ta Department of He	alth				APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/20	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING					
			NIA, MN 5592	PROVIDER'S PLAN OF (		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 680	Continued From pa	ge 24	0 680			
	living director (LALI exit diagrams were assisted living servi locked memory car LALD-A verified at t					
	Preparedness Polic indicated the licens diagrams on each f	ister Planning and Emergency cy dated August 1, 2021, e would post emergency loor, of the facility, and had a rocedure regarding missing				
	No additional inforn	nation was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
0 730 SS=E	144G.43 Subd. 3 C	ontents of resident record	0 730			
	following for each re (1) identifying inform name, date of birth, number; (2) the name, addres the resident's emer representatives, an (3) names, address the resident's health providers, if known; (4) health informatic allergies, and when	nation, including the resident's , address, and telephone ess, and telephone number of gency contact, legal d designated representative; ses, and telephone numbers of h and medical service				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		ATE SURVEY OMPLETED		
	33458		B. WING		12/30/2022			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE				
CLADDAGH SENIOR LIVING       508 KRUCKOW AVENUE NORTH         CALEDONIA, MN       55921								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
0 730	Continued From pa	age 25	0 730					
	records; (5) the resident's ar (6) copies of any hy guardianships, pow conservatorships; (7) the facility's cur assessments and s (8) all records of cor resident's services; (9) documentation resident's status ar the needs of the re the appropriate sup professional; (10) documentation needs of the reside appropriate superv professional; (11) documentation provided as identifi (12) documentation and reviewed the a (13) documentation any resolution; (14) a discharge su termination notice a when applicable; ai (15) other document chapter and releva status.	rent and previous service plans; ommunications pertinent to the of significant changes in the nd actions taken in response to sident, including reporting to pervisor or health care n of incidents involving the is taken in response to the ent, including reporting to the isor or health care n that services have been ed in the service plan; n that the resident has received ssisted living bill of rights; n of complaints received and ummary, including service and related documentation, nd ntation required under this nt to the resident's services or						
	by: Based on observat review, the license	ent is not met as evidenced ion, interview, and record e's registered nurse (RN) failed itation of weekly wound	ł					

ND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE S COMPLI	
		33458	B. WING		12/30/2022	
NAME OF F	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		KOW AVENU NA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 730	Continued From pa	-	0 730			
	provided for one of to ensure the reside discharge summary provided informatio	ed to document the services three residents (R3) and failed ent record included a v with the required content and n to the receiving facility as wo discharged residents (R4,				
	violation that did no safety but had the p resident's health or cause serious injury was issued at a pat limited number of re than a limited numb	ed in a level two violation (a t harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death) and tern scope (when more than a esidents are affected, more per of staff are involved, or the red repeatedly; but is not ve).				
	The findings include:					
	notes with wound de measurements for I (a wound at the bas	evidence of weekly nurse escription and wound R1's stage four coccyx wound se of the tailbone, with an Is through the skin tissue, e.)				
	four sacral pressure osteomyelitis (an in bone), benign prost urinary tract sympto in recurrent urinary arthritis (inflammatic	uded diabetes mellitus, stage e injury with history of fection/inflammation in the atic hyperplasia with lower oms (enlarge prostate resulting tract infections, and giant cell on of the lining of the arteries, ries in the head which can				

TATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 730	Continued From pa	ge 27	0 730			
	include medication	R1 received services to administration, blood glucose re and daily safety checks.				
	personnel (ULP)-F with medication adr check, and wound of ULP-F complete wo steps as directed of dated November 8, PM shift to complet changes twice daily dressing. 3. Use 2 y moistened with Ana switch back to Daki solution] once it run solution], 4. Apply p Cover with ABD page	2022, at 8:15 a.m. unlicensed was observed to assist R1 ministration, blood glucose care. The evaluator observed bund care with the following n R1's wound care instructions 2022, which read, "AM and e, 1. Continue with dressing 7. 2. Gently remove old x 2 inch gauze opened up and asept wound cleaner-Then will ins solution [cleansing hs out. [ULP-F used Dakins betroleum around wound 5. d [large rectangular shaped ] and affix with medipore tape rade tape].				
		Sheet dated December 2022, providing wound care twice				
	November 29, 2022 the times of 9:00 a. designated times for ULP documented in characteristics of the drainage color, would	ocumentation record dated 2-December 1, 2022, included m. and 5:00 p.m. as the or R1's dressing changes. The nformation for the following ne wound: drainage amount, and bed color, signs of area (other areas in the groin)				
	visit notes: -April 15, 2022, indi	d the following Wound Clinic icated wound location of of tailbone], wound exudate				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED		
		33458	B. WING		12/30/2022			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE				
CLADDAGH SENIOR LIVING       508 KRUCKOW AVENUE NORTH         CALEDONIA, MN       55921								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
0 730	Continued From pa	age 28	0 730					
	cm [centimeters] lo deep. -May 25, 2022, read daily wet to dry with gauze. Pack while I stomach. Make sur wound. Cover with been doing." -June 23, 2022, read nitrated [a chemical concerns and enha with current wound weeks, nurse only.' -July 9, 2022, read Pt [patient] will get 2 discuss next steps appointment. Conti sure packing reach Packing should cor so it's tight. Fluff, de -November 7, 2022 wound clean but de daily] dressings- us up and moistened w petroleum to periwe ABD, paper tape. D F/U [follow up] 6 [si R1's Nurse's Notes December 9, 2022, related to his coccy -July 30, 2022, read [R1] wound looks g wound clinic that it's is getting smaller." -August 28, 2022, r looks [written text is	"Wound now probes to bone. x-ray at his convenience and with [provider's name] at next nue same treatment. Make les base of the wound. mpletely fill the space but not on't stuff." 2, read "Wound clinic visit- eeper. Continue BID [twice se 2 x 2 [inch] gauze opened with Anasept wound cleanser, ound [wound on buttock area] Discontinue Dakins 0.125% , ix] weeks."						

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 730	Continued From pa -August 29, 2022, r back and stated his due to Covid. His w increased bloody d he does not have a to wound clinic and -November 7, 2022 today. Dressing cha ordered." On December 29, 2 nurse (RN)-B state time when I was the at least weekly, and practical nurse] and change]. Ok, need better, I see I'm mis visits." R3 R3's record lacked the services of groo mobility, assist with time, meals and so individual. R3's Service Plan A 2022, indicated R3 assessments, dres wheeling, continent medication adminis Med [medication]/T plan", behavior mo housekeeping and spot/safety checks	age 29 read "Wound clinic RN called s [R1] wound can change color yound today looks darker with rainage. No odor noted, and fever. This writer placed a cal	0 730	DEFICIENC	ΥY)	
	stated staff dressed	2022, at 3:00 p.m. ULP-D d R3, toilet R3 every three of incontinent product, staff				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 730	Continued From pa	age 30	0 730			
	R3 could brush her	(mechanical lift) to transfer R3, r own teeth with assist to set up staff comb R3's hair.				
	identified staff were services of activitie full assist, bathing intervention, dressi laundry, medication care assist, CPAP	g Sheet dated December 2022, e signing for providing the es escort, ambulation/transfer full assist, behavior ing full assist, housekeeping, n assist, nail care assist, oral assist, safety assistance, e and whereabouts check.				
	signatures for prov assistance with gro positioning, bed mo	documented evidence of staff iding the services of poming-assist with hair care, obility, orientation-assist with on, place, time, meals and and individual.				
	and RN-B verified s services of assistant hair care, positionin orientation-assist w place, time, meals individual to R3. LA service plan dated R3's service plan la grooming-assist wi mobility, orientation person, place, time socialization/group RN-B verified R3's	vith orientating to person, and socialization/group and ALD-A and RN-B reviewed R3's August 4, 2022, and verified acked services of th hair care, positioning, bed n-assist with orientating to				
	and was discharge	g services on May 14, 2022, d on November 25, 2022. R4's l congestive heart failure.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
0 730	Continued From pa	ge 31	0 730			
	indicated we addree another facility with worker (at hospital) R4's progress note indicated "discharg worker (at hospital) found for R4. Repo from the facility. All ability. R4 has been R4's undated, Discl following: resident's name and phone ne admission informat date: Discharge info discharge (moved t to (name and city); at hospital for past Discharge Summar Inventory and Dest	dated September 20, 2022, ssed R4's wish to move to social worker. Gave social information of other facilities. dated November 22, 2022, e summary". Notified by social that another facility has been rt given to person who called questions answered to best of h discharged from this facility. harge Summary included the s name; date of birth; physiciar umber; allergies; diagnoses; ion including: start of care ormation including: reason for to another facility); discharged condition upon discharge: was two months. In addition, R5's ry included Record of the ruction of Controlled and ances for medications dated	F			
	include: - course of illness; - treatments and the - pertinent lab, radio and - a final summary of latest assessment of	a discharge summary to erapies; ology, and consultation results f the resident's status from the or review including baseline , behavioral, and functional				
	status In addition, R4's red evidence of providi	cord lacked documented ng the following information in ring facility to include:				

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 730	Continued From pa	age 32	0 730			
	name and address contact for addition - names and addre or community conta to the facility; - the resident's mos if the resident has r facility; and - the resident's curr	dress of the facility and the of a person at the facility to al information; sses of any significant social acts the resident has identified st recent service or care plan, received services from the rent "do not resuscitate" order er for life-sustaining treatment,				
	and was discharge	g services on July 27, 2021, d on August 4, 2022. R5's l intestinal obstruction.				
	R5's family membe needing nursing ho	dated July 29, 2022, indicated er was in agreement to R5 ome placement due to the everyday. "We will assist with it."				
	indicated "discharg moved R5 to the nu current needs. R5 ambulance. Hospic home. D/C (discha home name) nursir	dated August 4, 2022, e summary". Family voluntary ursing home due to R5's was transported by e will follow R5 to the nursing rge) summary sent to (nursing ng. Spoke to social services. can call with any further				
	following: resident i name and phone n admission informat date: reason for ini	harge Summary included the name; date of birth; physician umber; allergies; diagnoses; tion including: start of care tiation of services; responsible eived: ADL support, behavior				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/	12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE	
0 730	other: spot checks; including: reason for facility, move to hig to (name, address, upon discharge: sta given to social work addition, R5's Disch Record of the Inver Controlled and Unc medications dated // R5's record lacked include: - course of illness; - treatments and the - pertinent lab, radio and - a final summary of latest assessment of and current mental, status	cation management services, Discharge information or discharge (moved to another her level of care); discharged phone number); condition able and alert; notes: report ser at nursing home. In harge Summary included atory and Destruction of ontrolled substances for August 5, 2022. a discharge summary to	ŗ				
	writing to the receiv - the name and add name and address contact for additiona- - the resident's mos if the resident has re- facility; and - the resident's curr	ing facility to include: Iress of the facility and the of a person at the facility to	Π				
		2022, at 12:30 p.m., LALD-A R4 and R5's records lacked ed above.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 730	Continued From pa	ge 34	0 730			
	Content policy date the licensee would accurate records fo receiving assisted li documentation that as identified in the significant changes actions taken in res resident, including r supervisor or health records or commun resident's services	dent Record Information and d August 1, 2021, indicated maintain appropriate and r each resident that was iving services, including services have been provided service plan; documentation of in the residents status and ponse to the needs of the reporting to the appropriate n care professional and all nications pertinent to the and a discharge summary, rmination notice and related en applicable.	F			
	July 27, 2022, indic discharge summary licensee would prov resident's consent, and case manager, summary that include	·				
	TIME PERIOD FOF Twenty-One (21) da	R CORRECTION:				
0 810 SS=F	144G.45 Subd. 2 (b physical environme	o)-(f) Fire protection and nt	0 810			
	maintain fire safety plans shall include	iving facility shall develop and and evacuation plans. The but are not limited to: umber of resident sleeping				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		33458		B. WING		12/30/2022	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		12/	30/2022	
CLADDA	AGH SENIOR LIVING		NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
0 810	Continued From pa	age 35	0 810				
	<ul> <li>(2) employee actia a fire or similar emails a fire or similar emails (3) fire protection residents; and</li> <li>(4) procedures for evacuation, or reloce emergency including or unusual residents evacuation.</li> <li>(c) Employees of a receive training on plans upon hiring a thereafter.</li> <li>(d) Fire safety and readily available at (e) Residents who their own evacuation proper actions to tainclude movement, training shall be maileast once per year f) Evacuation drills twice per year per sevacuation is not record the residents is not activation is not record the residents is not activation plans a documentation. Thability to affect all s</li> </ul>	ions to be taken in the event of ergency; procedures necessary for or resident movement, cation during a fire or similar ng the identification of unique t needs for movement or ssisted living facilities shall the fire safety and evacuation nd at least twice per year evacuation plans shall be all times within the facility. are capable of assisting in on shall be trained on the ake in the event of a fire to evacuation, or relocation. The ade available to residents at to are required for employees shift with at least one ery other month. Evacuation of required. Fire alarm system quired to initiate the evacuation ent is not met as evidenced ion, and staff interview, the detailed fire safety and nd associated confirming is deficient condition has the					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		10/00/0000	
					12/	30/2022
	PROVIDER OR SUPPLIER		DRESS, CITY, S <sup>-</sup> CKOW AVENL			
CLADDA	AGH SENIOR LIVING		NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>\</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 810	Continued From pa	ge 36	0 810			
	was issued at a wid problems are perva	y, impairment, or death), and lespread scope (when sive or represent a systemic cted or has potential to affect I of the residents).				
	survey staff observe presented during do confirm that resider assisting in their ow	ween 11:30 AM TO 02:30 PM, ed that no documentation was ocumentation review to hts that are capable of <i>n</i> evacuation are being er actions at least once a year.				
	MD-C verbally conf observations.	irmed survey staff				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
0 970 SS=C	144.50 Subd. 5 Wa	ivers of liability prohibited	0 970			
	liability for the healt property of a reside include any provision should know to be of unenforceable under include any provision	not include a waiver of facility h and safety or personal int. The contract must not on that the facility knows or deceptive, unlawful, or er state or federal law, nor on that requires or implies a care or responsibility than is				
	by: Based on interview licensee failed to er contract did not incl	ent is not met as evidenced and record review, the nsure the assisted living ude language waiving the health, safety, or personal				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
0 970	Continued From pa	ge 37	0 970				
	property of a reside affect all 37 resider	ent. This had the potential to its.					
	violation that has no a minimal impact of affect health or safe widespread scope or represent a syste	ed in a level one violation (a o potential to cause more than n the resident and does not ety) and was issued at a (when problems are pervasive emic failure that has affected affect a large portion or all of					
	The findings include	ed:					
	The licensee had a renewal date of Au	n assisted living license with a gust 1, 2022.					
	R1's Assisted Living November 22, 2021	g Contract was signed 1.					
	R2's Assisted Living September 1, 2021	g Contract was signed					
	R3's Assisted Living September 6, 2021	g Contract was signed					
	following: -Page 13, number 2 occupant of [license the risk for Resident's will indemnify and h employees, officers agents from and ag actions, damages, connection with los damage to property	Contract included the 23. Indemnification-As an ee name], Resident assumes it's own safety and for the s guests and agents. Resident hold harmless Provider, its s, managers, owners and gainst any and all claims, and liability and expense in s of life, personal injury or y, arising from or out of, or part by, an act or omission of					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		33458	B. WING		12/3	12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	-		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
0 970 0 1060 SS=F	<ul> <li>-Page 13, number 2 liable to Resident of injury, death or prop Apartment or on Pre- injury, death or prop result of Provider's omissions, or those managers, owners liable for any injury, as the result of Res health-related, supp third-party providers aforementioned exc agrees to hold Prov claims for injuries, p loss resulting from a occurrence in the A premises.</li> <li>On December 29, 2 assistant living direct licensee's lawyer w advocacy agency. L aware this part of the stated she would con know.</li> <li>No further information TIME PERIOD FOF (21) days</li> <li>144G.52 Subd. 9 Efiliable</li> <li>(a) A facility may rest facility in an emerged</li> </ul>	25. Liability-Provider is not r Resident's guests for any perty damage occurring in the ovider's premises unless such perty damage occurs as the own negligent acts or e of its employees, officers, or agents. Provider is also not death or damage occurring ident's receipt of portive or other services from s. Unless caused by one of the cepted reasons, Resident rider harmless from any and al property damage or any other an accident or other partment or on Provider's 2022, at 12:30 p.m. licensed ctor (LALD)-A stated the orked closely with a state ALD-A stated she was not ne contract was prohibited and ontact the lawyer to let them	; 				

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
LADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5) COMPLET
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE
01060	Continued From pa	ge 39	01060			
	An emergency relocation is not a termination.					
		in emergency relocation, the				
	facility must provide at a minimum:	e a written notice that contains	,			
	(1) the reason for th	e relocation:				
		ontact information for the				
		e resident has been relocated				
	and any new servic					
		tion for the Office of				
	Ombudsman for Lo	plicable, the approximate date				
		ithin which the resident is				
		to the facility, or a statement				
		not currently known; and				
		t, if the facility refuses to				
		services after a relocation, the				
		ht to appeal under section ty must provide contact				
		agency to which the resident				
	may submit an app	<b>o</b> ,				
		ired under paragraph (b) must				
		on as practicable to:				
		al representative, and				
	designated represe	o receive home and				
		vaiver services under chapter				
		56B.49, the resident's case				
	manager; and					
		nbudsman for Long-Term Care	•			
		been relocated and has not				
	returned to the facil	nergency relocation, a facility's				
		ousing or services constitutes				
		iggers the termination process				
	in this section.					
	This MN Dequirers	ont is not mot as suideness				
	by:	ent is not met as evidenced				
	5	and record review, the				
		ovide a written notice with				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01060	Continued From pa	ge 40	01060			
	four of four resident to notify the Office of	r an emergency relocation for ts (R1, R2, R3, R4) and failed of Ombudsman for Long-Term ency relocation for three of four R4).				
	violation that did no safety but had the p resident's health or widespread scope ( or represent a syste	ed in a level two violation (a t harm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include	e:				
	R1 R1 was admitted to November 23, 2021	assisted living services on 1.				
	indicated R1 receiv	lated September 14, 2022, ed services to include tration, blood glucose checks, ily safety checks.				
	indicated the licens then to the hospital urine and R1 comp R1 was hospitalized	dated September 8, 2022, ee sent R1 to urgent care and due to concerns with blood in laints of burning with urination. d with a urinary tract infection k to the facility on September a later).				
	R2 R2 was admitted to August 12, 2021.	assisted living services on				
		Addendum dated August 22, received services to include				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	ECONSTRUCTION		E SURVEY PLETED	
			A. BUILDING.	DING:			
		33458	B. WING		12/30/2022		
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLE	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE	
01060	Continued From pa	age 41	01060				
	dressing, bathing, toileting assistance, medication management, blood glucose checks, catheter assistance, insulin injections and bowel tracking.						
	indicated the licens ambulance due to pressure and vomi	es dated August 29, 2022, see sent R2 to the hospital via catheter discomfort, low blood ting. R2 was hospitalized for a on and returned to the facility 022 (eight days).					
	contained, at a min - the reason for the - the name and cor location to which th and any new servic - contact informatic Ombudsman for Lo - if known and appl or range of dates w expected to return that a return date is - a statement that, housing or services resident has the rig 144G.54. The facili	e relocation; ntact information for the ne resident has been relocated ce provider; on for the Office of ong-Term Care; licable, the approximate date within which the resident is to the facility, or a statement s not currently known; if the facility refuses to provide s after a relocation, the ght to appeal under section ity must provide contact agency to which the resident					
	notification to the C Long-Term Care th	R2's records lacked Office of Ombudsman for re resident had been relocated ed to the facility within four					
	R3 R3 was admitted to June 7, 2021.	o assisted living services on					

Minneso	ota Department of He	alth			FURI	APPROVE
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING	B. WING		30/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE	COMPLETE DATE
01060	Continued From pa	ge 42	01060			
	2022, indicated R3 assessments, drest wheeling, continent medication adminis monitoring or interv linens, personal lau care, activities esco safety assistance c R3's record identifie -Notes dated March discharged from the returning. She has changes and will st occupational/physic -Discharge Summa 2022, indicated stal diagnoses recurren March 2, 2022; Dat (overnight stay). -Discharge Summa	ed the following: a 3, 2022, R3 will be a hospital today and be had a couple of medication art having cal therapy. ary hospital dated March 3, ble for discharge and t falls. Date of admission was e of discharge March 3, 2022 ary hospital print date July 25, e of admission was July 22,				
	and was discharge	services on May 14, 2022, d on November 25, 2022. uded congestive heart failure.				
	R4 received service positioning and bec continence-assist w cleansing and perir administration, pha deliver meds, beha congregate meal, h personal laundry, tr	lated June 23, 2022, indicated es including dressing, bathing, I mobility, transfers, vith toileting, incontinence, heal area, medication rmacy coordination to fill and vior monitoring or intervention, ousekeeping and linens, ansportation arrangement, I'm ok' checks, routine				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01060	Continued From pa	ge 43	01060			
	delegated RN on ca activities.	all 24/7 and reminder for				
	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.					
		harge Summary included harge: "was at [name] hospita s."				
	contained, at a min - the reason for the - the name and con location to which th and any new servic - contact informatio Ombudsman for Lo - if known and appli or range of dates w expected to return that that a return date is - a statement that, if housing or services	relocation; ttact information for the e resident has been relocated e provider; n for the Office of				
	144G.54. The facili	ty must provide contact agency to which the resident				
		cord lacked notification to the nan for Long-Term Care the				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/30/2022	
			A. BOILDING.			
		33458	B. WING			
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01060	Continued From pa	ge 44	01060			
	resident had been r to the facility within	elocated and had not returned four days.				
	assisted living direct licensee had not be required above con	2022, at 2:30 p.m. licensed stor (LALD)-A stated the een providing a notice with the tent and had not been of Ombudsman for Long-Term rt this practice.				
	No further informati	on was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-One				
01370 SS=D	144G.61 Subd. 2 (a unlicensed personn	i) Training and evaluation of	01370			
	<ul> <li>unlicensed personn</li> <li>(1) documentation in provided;</li> <li>(2) reports of change to the supervisor dee (3) basic infection of pathogens;</li> <li>(4) maintenance of environment;</li> <li>(5) appropriate and hygiene and groom</li> <li>(i) hair care and base (ii) care of teeth, guid devices;</li> <li>(iii) care and use of (iv) dressing and ase (6) training on the pathogen (1) document (1) and (1</li></ul>	safe techniques in personal ing, including: thing; ms, and oral prosthetic hearing aids; and ssisting with toileting;				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADD	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01370	Continued From pa	age 45	01370			
	reminders; (9) basic nutrition, r and assistance with (10) preparation of licensed health pro (11) communication the dignity of the re the resident and the cultural background (12) awareness of (13) understanding between staff and r family; (14) procedures to emergency situatio (15) awareness of technology equipm This MN Requirem by: Based on observat review, the licensee competency evalua for two of two unlice ULP-D). This practice result violation that did no safety but had the p resident's health or cause serious injur was issued at an is limited number of r	modified diets as ordered by a fessional; in skills that include preserving esident and showing respect for e resident's preferences, d, and family; confidentiality and privacy; appropriate boundaries residents and the resident's use in handling various ns; and commonly used health ent and assistive devices. ent is not met as evidenced ion, interview, and record e failed to ensure training and ations for the required topics ensed personnel (ULP-F, ted in a level two violation (a ot harm a resident's health or potential to have harmed a residents are affected or one or a esidents are affected or one or f staff are involved or the red only occasionally).				

STATE FORM

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI ND PLAN OF CORRECTION IDENTIFICATION NI		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		_			
	33458	B. WING		12/30/2022	
ROVIDER OR SUPPLIER					
GH SENIOR LIVING					
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACT	ION SHOULD BE	(X5) COMPLET DATE
		170			
Continued From pa	ge 46	01370			
provided direct care	e services under the licensee's				
observed to assist I	R1 with medication				
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					
demonstrated comp training completed -appropriate and sa hygiene and groom gums, and oral pros -care and use of he -dressing and assis	petency but lacked evidence of prior to providing services: afe techniques in personal ing, including: care of teeth, sthetic devices; earing aids; sting with toileting; and				
	(EACH DEFICIENCY REGULATORY OR L Continued From pa ULP-F had a hire d provided direct care assisted living with On December 28, 2 observed to assist administration, bloc care. ULP-F's record lack to providing service -reports of changes the supervisor desi -maintenance of a d -medication, exerci -preparation of mod licensed health pro- communication sk dignity of the resider resident and the resider staff and residents -procedures to use emergency situatio -awareness of com equipment and ass The following topics demonstrated comp training completed -appropriate and sa hygiene and groom gums, and oral pro- care and use of he -dressing and assis -standby assistance perform them.	GH SENIOR LIVING       508 KRUC CALEDO         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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	PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST         508 KRUCKOW AVENU CALEDONIA, MN 5592         Image: Summary Statement of Deficiencies (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Image: Summary Statement of Deficiencies (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Image: Summary Statement of Deficiencies         Continued From page 46       01370         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.       0         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.       0         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,	PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           GH SENIOR LIVING         STREET ADDRESS, CITY, STATE, ZIP CODE           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         PROVIDER'S PLAN OF (EACH CORRECTIVE ACT (EACH DEFICIENCY MUST TAG           Continued From page 46         01370         01370           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.         01370           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.         01370           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 asis two devices           The following topics identified evidence of training completed prior to providing ser	ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         GH SENIOR LIVING       STREET ADDRESS, CITY, STATE, ZIP CODE         GH SENIOR LIVING       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCY       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       ID         REGULATORY OR LSC DENTIFYING INFORMATION)       PRE-FIX         Continued From page 46       01370         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.       0         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.       0         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; 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	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE. ZIP CODE	1	
			CKOW AVENU			
CLADDA	GH SENIOR LIVING	CALEDO	NIA, MN 5592	:1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
01370	Continued From pa	ige 47	01370			
	stated, "we have ac reflect what is requi don't understand ho Educare prior to the be a glitch in the sy training print out inc missing and late da stated, "yes, it need ULP-D ULP-D had a hire d	ted living director (LALD)-A djusted the Educare system to ired with an auto-enrollment. I bow these were not captured in a dates listed here, there must rstem." Review of Educare dicated training topics still ates of completion, LALD ds to be done." late of August 31, 2022, and e services to the licensee				
	-	2022, at 8:14 a.m. ULP-D was ster medications to R3.				
	completed training -documentation req provided; -reports of changes the supervisor desi -maintenance of a -appropriate and sa hygiene and groom (i) hair care and ba (ii) care of teeth, gu	uirements for all services in the resident's condition to gnated by the facility; clean and safe environment; afe techniques in personal ing, including:				
	-training on the pre- -standby assistance perform them; -exercise, and treat -basic nutrition, me and assistance with	ssisting with toileting; vention of falls; e techniques and how to tment reminders; al preparation, food safety,				
nnesota D	licensed health prot					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		33458	B. WING		12/	12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE, ZIP CODE				
			KOW AVENU				
CLADDA	GH SENIOR LIVING	CALEDO	NIA, MN 5592	21			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
01370	Continued From pa	age 48	01370				
	resident and the re- background, and fa -understanding app staff and residents -awareness of com equipment and ass ULP-D's record lac completed compete -standby assistance perform them ULP-D's record inc (online computer tr obtained from a pri- December 28, 2022 manager (HM)-C st for the content" of t training". HM-C sta	propriate boundaries between and the resident's family; monly used health technology					
	training. On December 30, 2 RN-B reviewed ULI ULP-D's record lac	ed under the topics of Relias 2022, at 9:28 a.m. LALD-A and P-D's record and verified ked documented evidence of istrated competency ibove.					
	Services policy data registered nurse or may delegate tasks competent and pos consistent with the according to the ap	egation of Assisted Living ed August 1, 2021, read a licensed health professional s only to staff who are sess the knowledge and skill complexity of the tasks and propriate Minnesota practice					
	professional delega	stered nurse or licensed health ates tasks to ULP, that person or to the delegation the ULP is					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
01370	trained in the prope	ge 49 er methods to perform the s for each resident and is able	01370				
		ability to competently follow					
	policy dated August hire and prior to per position, each new be oriented in acco regulation, as well a procedure. An orier completed by the e	eral Employee Orientation t, 14, 2021, indicated "Upon rforming any functions of their employee and volunteer will rdance with State and Federal as company policy and ntation checklist will be mployee and trainer, signed by vill be filed in the employee's					
	No further informati	ion was provided. R CORRECTION: Twenty-one					
01380 SS=D	(21) days 144G.61 Subd. 2 (b unlicensed personr	b) Training and evaluation of	01380				
	competency evalua providing assisted I (1) observing, repor resident status; (2) basic knowledge changes in body fur observed changes appropriate person (3) reading and rec and respirations of (4) recognizing phy and developmental (5) safe transfer tec	ording temperature, pulse,					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		ICKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01380	Continued From pa	age 50	01380			
	(7) administering m required.	nedications or treatments as				
	by: Based on observat review, the license training and evalua required prior to pro	ent is not met as evidenced ion, interview and record e failed to ensure competency tions were completed as oviding direct care for two of sonnel (ULP-D, ULP-F).				
	violation that did no safety but had the resident's health or cause serious injur was issued at an is limited number of a limited number of	ted in a level two violation (a of harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and solated scope (when one or a esidents are affected or one of f staff are involved or the red only occasionally).	r			
	The findings includ	e:				
	provided direct car	late of May 17, 2021, and e services under the licensee's dementia care license.	3			
	observed to assist	2022, at 8:15 a.m. ULP-F was R1 with medication od glucose check, and wound				
	for Educare training competency trainin completed the follo	raining record "My transcript" g program and Educare g documents indicated ULP-F wing competencies, but lacked le training requirements prior to	b			

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		33458	B. WING		12/	12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		ICKOW AVENU DNIA, MN 5592				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
01380	Continued From pa	ige 51	01380				
	respirations of the	niques and ambulation; and					
	required training to -basic knowledge c changes in body fu observed changes appropriate person	al, emotional, cognitive, and					
	assisted living direct adjusted the Educat required with an aut understand how the Educare prior to the be a glitch in the sy training print out ind missing and late da stated, "yes, it need ULP-D ULP-D had a hire co	2022, at 9:30 a.m. licensed ctor (LALD)-A stated, "we have are system to reflect what is to-enrollment. I don't ese were not captured in e dates listed here, there must rstem." Review of Educare dicated training topics still ates of completion, LALD ds to be done." late of August 31, 2022, and e services to the licensee's					
		2022, at 8:14 a.m. ULP-D was ster medications to R3.					
	completed training -basic knowledge c changes in body fu observed changes appropriate person	of body functioning and nctioning, injuries, or other that must be reported to					

STATE FORM

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/	12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
01380	Continued From pa	ge 52	01380				
	-recognizing physic developmental nee -ambulation; and -range of motioning ULP-D's record lac completed compete -ambulation; -range of motioning -CPAP ULP-D's record inc (online computer tra	al, emotional, cognitive, and ds of the resident; and positioning ked documentation of ency for the following: g; and luded a Relias Transcript aining) for training topics					
	December 28, 2022 manager (HM)-C st for the content" of t training". HM-C sta training here", so st	or employer; however, on 2, at 10:38 a.m. housing tated she had "no information he topics for the "Relias ated, "We don't use Relias he would not know what ad under the topics of the					
	RN-B reviewed ULI ULP-D's record lac	2022, at 9:28 a.m. LALD-A and P-D's record and verified ked documented evidence of strated competency bove.					
	Services policy data registered nurse or may delegate tasks competent and pos consistent with the according to the ap act. When the regis professional delega will ensure that price	egation of Assisted Living ed August 1, 2021, read a licensed health professional conly to staff who are sess the knowledge and skill complexity of the tasks and propriate Minnesota practice stered nurse or licensed health ates tasks to ULP, that person or to the delegation the ULP is er methods to perform the					

	ota Department of He	(X1) Provider/Supplier/Clia	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING					
(X4) ID	SUMMARY STA		NIA, MN 5592	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLETE DATE
01380	Continued From pa	ge 53	01380			
	to demonstrate the the procedures and	ability to competently follow perform the tasks.				
	policy dated August hire and prior to per position, each new be oriented in accor regulation, as well a procedure. An orier completed by the er each person, and w record."	eral Employee Orientation t, 14, 2021, indicated "Upon forming any functions of their employee and volunteer will rdance with State and Federal as company policy and ntation checklist will be mployee and trainer, signed by vill be filed in the employee's				
	No further informati TIME PERIOD FOF (21) days	on was provided. R CORRECTION: Twenty-one				
01420 SS=D	144G.62 Subd. 2 D services	elegation of assisted living	01420			
	professional delega personnel, that pers the delegation the u in the proper metho procedures for each demonstrate the ab procedures and per unlicensed personn the delegated assis 24 consecutive mon must demonstrate or professional. The re health professional	ered nurse or licensed health ites tasks to unlicensed son must ensure that prior to inlicensed personnel is trained ods to perform the tasks or in resident and is able to ility to competently follow the form the tasks. If an iel has not regularly performed ted living task for a period of inths, the unlicensed personnel competency in the task to the appropriate licensed health egistered nurse or licensed must document instructions isks in the resident's record.				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	GH SENIOR LIVING		CKOW AVENU			
		CALEDO	NIA, MN 5592	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01420	Continued From pa	ge 54	01420			
	by: Based on observati review, the licensee registered nurse (R competency evalua personnel (ULP-F, delegated tasks. This practice result violation that did no safety but had the p resident's health or cause serious injury was issued at an iss limited number of re a limited number of	ent is not met as evidenced ion, interview, and record a failed to ensure the N) conducted training and titons for two of two unlicensed ULP-D) who performed ed in a level two violation (a ot harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally). e:				
	provided direct care assisted living with ULP-F's record incl Mobility Lifting and 2021, which lacked for "transfer using" steps included the f 1. Caregiver should 2. Inform client of m initiated. 3. Caregiver assists knees and placing f 4. Caregiver rolls cl	I move slowly. novements prior to them being s client with bending client's their feet on the bed.	,			

STATE FORM

BBXB11

If continuation sheet 55 of 165

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01420	Continued From pa	age 55	01420			
	pulls sling through 7. Caregiver rolls c	so it is lying flat on the bed. lient back.				
	evidence for trainin competency evalua transferring a resid to attach the sling s		/			
	evidence of training competency evalua chair (a specialized	i's record lacked documented g and demonstrated ation with the use of the Broda I wheelchair) and EZ stand (lift transfer a resident while in a				
	assisted living direct named equipment facility and the train	2022, at 9:50 a.m. licensed ctor (LALD)-A stated the above was used by ULP within the ning should have been in there and verified it was not in file.				
		late of August 31, 2022, and e to the licensee residents.				
		2022, at 3:00 p.m. ULP-D n EZ stand to transfer R3.				
		2022, at 8:14 a.m. ULP-D was ister medications to R3 who oda chair.				
		luded Skill Competency Client Safe Transfers dated October				

STATE FORM

If continuation sheet 56 of 165

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/	12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
01420	Continued From pa	age 56	01420				
	<ul> <li>a Hoyer lift from be following:</li> <li>1. Caregiver should</li> <li>2. Inform client of n initiated.</li> <li>3. Caregiver assists knees and placing</li> <li>4. Caregiver rolls c</li> <li>5. Caregiver rolls c</li> <li>back.</li> <li>6. Caregiver rolls c</li> <li>pulls sling through</li> <li>7. Caregiver rolls c</li> <li>ULP-D's record lac evidence for training</li> </ul>	novements prior to them being s client with bending client's their feet on the bed. lient to the side. s half open sling under clients lient to the opposite side and so it is lying flat on the bed.					
	transferring a resid to attach the sling s operate the Hoyer f wheelchair/chair, tr wheelchair/chair to ULP-D's record lac	ent for surface to surface (how straps to the Hoyer, how to for transferring from bed to ansferring from bed). ked evidence of training and					
	demonstrated com chair and EZ stand	petency evaluation for BRODA lift and Hoyer lift.					
	RN-B stated the lic stand and Hoyer lif ULP-D's record and lacked documented	2022, at 9:28 a.m. LALD-A and ensee utilized the use of EZ ts. LALD-A and RN-B reviewed d verified ULP-D's record d evidence of training and petency evaluation for BRODA and Hoyer lift.					
	Services policy dat registered nurse or	egation of Assisted Living ed August 1, 2021, read a licensed health professional s only to staff who are					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/30/2022	
		33458	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		KOW AVENU NA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01420	consistent with the according to the ap act. When the regis professional delega will ensure that prio trained in the prope tasks or procedures to demonstrate the the procedures and No further informati	sess the knowledge and skill complexity of the tasks and propriate Minnesota practice tered nurse or licensed health tes tasks to ULP, that person r to the delegation the ULP is r methods to perform the s for each resident and is able ability to competently follow perform the tasks.	01420			
01440 SS=D	delegated nurs (a) Staff who perfor therapy tasks must appropriate licensed registered nurse ac facility's policy wher provided to verify th performed compete and solutions relate to perform the tasks performing medicat administration shall nurse or appropriate and must include of administering the m interaction with the (b) The direct super delegated tasks mu calendar days after individual begins wo	ently and to identify problems d to the staff person's ability s. Supervision of staff ion or treatment be provided by a registered e licensed health professional oservation of the staff redication or treatment and the	01440			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		33458	B. WING		12/	12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		KOW AVENU				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
01440	Continued From pa	ge 58	01440				
	requirement also ap	ed based on performance. This oplies to staff who have not ed tasks for one year or longer.					
	by: Based on observati review, the licensee supervision of staff was provided within date on which the in the licensee for two (ULP-F, ULP-D). This practice result violation that did no safety but had the p resident's health or cause serious injury was issued at an is limited number of re a limited number of	ent is not met as evidenced on, interview, and record e failed to ensure direct performing delegated tasks a 30 calendar days after the ndividual begins working for o of two unlicensed personnel ed in a level two violation (a t harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or f staff are involved or the red only occasionally).					
	provided direct care	e: ate of May 17, 2021, and e services under the licensee's dementia care license.					
	On December 28, 2 was observed to as	2022, at 8:15 a.m. (ULP)-F sist R1 with medication od glucose check, and wound					
		record lacked evidence ULP-F hin 30 days of performing					

STATEMEN	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		33458	B. WING		12/	30/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		508 KRU	CKOW AVENU	JE NORTH		
CLADDA	AGH SENIOR LIVING	CALEDO	NIA, MN 5592	21		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5) COMPLET
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1		DATE
				DEFICIENC	SY)	
01440	Continued From pa	ae 59	01440			
		3				
	On December 30	2022, at 10:08 a.m. RN-B				
		pleted the supervision but				
		nent it. Licensed assisted living				
		tated "It should have been on				
		harge of employee files did not				
		esn't look like it is in the file,				
	no."					
	ULP-D					
		ate of August 31, 2022, and				
	provided direct care	e to the licensee's residents.				
	On December 28. 2	2022, at 8:14 a.m. ULP-D was				
		ster medications to R3.				
	UI P-D's personnel	record lacked evidence				
		sed within 30 days of				
	performing delegated tasks.					
		2022, at 9:28 a.m. RN-B record and stated "Okay. We				
		bly not documented".				
		ing not documented .				
	The licensee's Sup	ervision of Staff-Delegated				
		ed August 1, 2021, indicated				
		elegated nursing or therapy				
		t [licensee name] will be				
		N or appropriate licensed				
		where the services are being				
		at work is being performed				
		identify problems and the staff person's ability				
		Supervision will include				
		staff administering the				
		ment and the interaction with				
		ervision of staff performing				
	delegated tasks mu	ist be provided within 30				
		the date on which the				
		orking for [licensee name] and				
	first performs the de	elegated tasks for residents				

	ta Department of He			CONSTRUCTION		
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		508 KRU	CKOW AVENL	JE NORTH		
CLADDA	GH SENIOR LIVING	CALEDO	NIA, MN 5592	21		
(X4) ID		TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE
				DEFICIENC	(Y)	
01440	Continued From pa	ge 60	01440			
	and thereafter as needed based on performance.					
		upervision activities will be				
	retained in the emp	loyee's record.				
	No further informati	on was provided				
		R CORRECTION: Twenty-one				
	(21) days					
01470	1440 62 Subd 2 C	antant of required arientation	01470			
01470 SS=D	144G.03 Subd. 2 C	ontent of required orientation	01470			
		must contain the following				
	topics:					
	(1) an overview of t					
		and review of the facility's ures related to the provision				
		rvices by the individual staff				
	person;					
		rgencies and use of				
	emergency services					
		and reporting of the				
		nerable adults under section				
	Center (MAARC);	nesota Adult Abuse Reporting				
		ng bill of rights and staff				
		ted to ensuring the exercise				
	and protection of th	ose rights;				
		person-centered planning				
		and how they apply to direct				
		ovided by the staff person;				
		lents' complaints, reporting of ere to report complaints,				
		n on the Office of Health				
	Facility Complaints;					
		cacy services of the Office of				
		ng-Term Care, Office of				
	Ombudsman for Me					
	Developmental Disa	abilities, Managed Care				

Minnesota Department of Health STATE FORM

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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE	COMPLET DATE
01470	Continued From pa	age 61	01470			
	Services, county-mo other relevant advo (9) a review of the first services the emploind facility's category of (b) In addition to the orientation may alse services to residen training on hearing subdivision must be based, may include include training on topics: (1) an explanation of and how it manifes the challenges it po (2) health impacts of age-related hearing incidence of demer isolation, and depre (3) information about that may enhance of and tactile alerting access in real time This MN Requirem by: Based on observat review, the licensed providing services of assisted living facili regulations before two unlicensed per This practice result	types of assisted living yee will be providing and the f licensure. e topics in paragraph (a), o contain training on providing ts with hearing loss. Any loss provided under this e high quality and research e online training, and must one or more of the following of age-related hearing loss ts itself, its prevalence, and oses to communication; related to untreated g loss, such as increased ntia, falls, hospitalizations, ession; or ut strategies and technology communication and ling communication strategies, devices, hearing aids, visual devices, communication , and closed captions. ent is not met as evidenced ion, interview, and record e failed to ensure staff completed an orientation to ity licensing requirements and providing services for two of sonnel (ULP-F and ULP-D).				
nnesota Do		ed in a level two violation (a ot harm a resident's health or				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		33458	B. WING	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•		
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
01470		ige 62 potential to have harmed a	01470				
	resident's health or cause serious injury was issued at an is limited number of a limited number of	safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or f staff are involved or the red only occasionally).					
	The findings include	e:					
	ULP-F ULP-F had a hire d	ate of May 17, 2021.					
	observed to admini	2022, at 8:05 a.m. ULP-F was ster medications, check a complete wound cares for R1.					
	orientation to assist (144G.63, Sub. 2) e the following: - the principles of p service delivery and	ked documented evidence of ted living regulations effective August 1, 2021, for erson-centered planning and d how they apply to direct ovided by the staff person;					
	- consumer advoca Ombudsman for Lo Ombudsman for Mo Developmental Dis Ombudsman at the	abilities, Managed Care Department of Human anaged care advocates, or					
	of the record, licens (LALD)-A stated, "T is overseeing, I'm n LALD-A then provid named "General Ou	2022, at 8:50 a.m. with review sed assisted living director "hat's strange, someone else not sure why this is not done." ded another training document rientation Checklist for New ver, this document lacked the					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01470	Continued From pa	ge 63	01470			
	provided direct care On December 28, 2 observed to admini ULP-D's record lack orientation to assist (144G.63, Sub. 2) et the following: -an overview of this -the principles of per- service delivery and support services pr -handling of resider complaints, and wh including informatic Facility Complaints: -consumer advocad Ombudsman for Lo Ombudsman for Lo Ombudsman for Ma Developmental Dist Ombudsman at the Services, county-m other relevant advo -a review of the typ the employee will b category of licensur On December 30, 2 RN-B reviewed ULF ULP-D lacked the a LALD-A stated, "It la	late of August 31, 2022, and e to the licensee residents. 2022, at 8:14 a.m. ULP-D was ster medications to R3. ked documented evidence of ted living regulations effective August 1, 2021, for a chapter; erson-centered planning and d how they apply to direct ovided by the staff person; nts' complaints, reporting of tere to report complaints, on on the Office of Health ; cy services of the Office of ental Health and abilities, Managed Care e Department of Human anaged care advocates, or teacy services; and es of assisted living services e providing and the facility's re. 2022, at 9:28 a.m. LALD-A and P-D's record and verified above orientation training. ooks like the wrong list" was care" program (online training)				
	The licensee's Emp	bloyee General Orientation t 14, 2021, indicated upon hire				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
01470	Continued From pa	ge 64	01470			
	position, each new be oriented in accor regulations, as well procedure. Addition perform job duties b	ning any functions of their employee and volunteer will rdance with State and Federal as company policy and ally, employees should not before the completion of b including general and safety				
	No further informati	on was provided.				
	TIME PERIOD FOR Twenty-One (21) da					
01540 SS=D	144G.64 (a) TRAIN REQUIRED	ING IN DEMENTIA CARE	01540			
	direct-care employed least eight hours of specified under part hours of the employ initial training is com- provide direct care employee on site w eight hours of trainin dementia care and and assist if issues requirements under meeting the require available for consul until the training rec Direct-care employed hours of training on	g facilities with dementia care, ees must have completed at initial training on topics agraph (b) within 80 working yment start date. Until this nplete, an employee must not unless there is another ho has completed the initial ng on topics related to who can act as a resource arise. A trainer of the paragraph (b) or a supervisor ments in clause (1) must be tation with the new employee quirement is complete. ees must have at least two topics related to dementia for employment thereafter;				
	by:	ent is not met as evidenced on, interview, and record				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/	12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE	
01540	review, the licensee staff completed all of dementia training a dementia care train for one of two empl (ULP)-D). This practice result violation that did no safety but had the p resident's health or cause serious injury was issued at an iss limited number of situation has occurr ULP-D ULP-D had a hire d provided direct care	e failed to ensure direct care of the the required topics for nd the required amount of ing in the required time frame oyees (unlicensed personnel ed in a level two violation (a t harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally). ate of August 31, 2022, and e to the licensee residents.	01540				
	observed to administ ULP-D's record incl Educare training (or identified a total of s training topics "com September 3, 15, 1 2022, and Relias Tr training program) w hours of dementia t the date of Decemb ULP-D's record lack required training for centered planning a evidence a total of o	2022, at 8:14 a.m. ULP-D was ster medications to R3. uded My Transcript for in line training program) which seven hours of dementia upleted" on the dates of 6, 2022, and November 29, ranscript training (on line hich identified a total of 0.50 raining topics "completed" on ber 26, 2021. Keed documented evidence of required topics of person and service delivery and eight hours of training was 0 hours of employment start					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		KOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
01540	On December 30, 2 RN-B reviewed ULF ULP-D lacked the a training. LALD-A sta The licensee's Emp policy dated August and prior to perform position each new e in accordance with Regulations, as wel procedure.	2022, at 9:28 a.m. LALD-A and P-D's record and verified above for dementia care ated, "Okay". Novee General Orientation 14, 2021, indicated upon hire ning any functions of their employee would be orientated State and Federal I as company policy and	01540			
01620 SS=G	(c) Resident reasses be conducted no m after initiation of sel reassessment and as needed based o resident and canno from the last date o (d) For residents or services specified in 9, clauses (1) to (5) individualized initial and preferences. The completed within 30 services. Resident be conducted as nee the needs of the resi- calendar days from	monitoring essment and monitoring must ore than 14 calendar days rvices. Ongoing resident monitoring must be conducted n changes in the needs of the t exceed 90 calendar days	01620			

Minneso	ota Department of He	alth	-			
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01620	Continued From pa	ge 67	01620			
	long-term care cons section 256B.0911, prospective resident facility or the date of resident moves in, w This MN Requiremed by: Based on observati review, the licensee registered nurse (R documented a com change in condition (ER) visits, readmis fall) for three of three failed to ensure the comprehensive mo reassessment for 9 three of three reside This practice result violation that harmen not including seriou or a violation that has serious injury, impa issued at an isolate limited number of re a limited number of situation has occurr The findings include R1 R1 had diagnoses to stage four sacral pr osteomyelitis (an in bone), benign prost	ent is not met as evidenced on, interview, and record e failed to ensure the N) had completed and/or prehensive assessment for (wounds, emergency room asion following hospitalization, ee residents (R1, R2, R3) and RN documented nitoring and review 0 days as required for for ents (R1, R2, R3). ed in a level three violation (a ed a resident's health or safety s injury, impairment, or death, as the potential to lead to irment, or death) and was d scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				

Minnesota Department of Health STATE FORM

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/30/2022	
		22459	B. WING			
	PROVIDER OR SUPPLIER	33458				
			DDRESS, CITY, ST I <b>CKOW AVENU</b>			
CLADDA	GH SENIOR LIVING		ONIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01620	Continued From pa	ge 68	01620			
	arteritis (inflammati	tract infections, and giant cell on of the lining of the arteries, ries in the head which can				
	14, 2022, indicated include medication	addendum dated September R1 received services to administration, blood glucose re and daily safety checks.				
	comprehensive ass ulcer wound of coc tailbone), including	WOUND documented evidence of sessment of coccyx pressure cyx (at the base of the consistent weekly assessmen earance, odor, drainage and	t			
		Sheet dated December 2022 providing wound care twice	,			
	November 29, 2022 the times of 9:00 a. designated times for ULP documented in characteristics of the drainage color, would	ocumentation record dated 2-December 1, 2022, included m. and 5:00 p.m. as the or R1's dressing changes. The nformation for the following ne wound: drainage amount, and bed color, signs of area (other areas in the groin)				
	visit notes: -April 15, 2022, ind "coccyxgeal" [base [drainage] moderat cm [centimeters] lo deep.	d the following Wound Clinic icated wound location of of tailbone], wound exudate e, wound measurements 4.2 ng x [by] 1.2 cm wide x 3.7 cm d "Wound care orders-Twice				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
01620	Continued From pa	ge 69	01620			
	gauze. Pack while p stomach. Make sur wound. Cover with pad bandage used wounds) as you hav -June 23, 2022, rea nitrate [a chemical concerns and enha with current wound weeks, nurse only." -July 9, 2022, read Pt [patient] will get 2 discuss next steps appointment. Conti sure packing reach Packing should con so it's tight. Fluff, do -November 7, 2022 wound clean but de daily] dressings- us up and moistened w petroleum to periwo ABD, paper tape. D F/U [follow up] 6 [si R1's Nurse's Notes December 9, 2022, read [R1] wound looks g wound clinic that it's is getting smaller." -August 28, 2022, r looks [written text is noted. Wound clinic the day." -August 29, 2022, r back and stated his	ad "Right side of wound silver used to treat various skin nce wound healing]. Continue cares. Wound center- 2 "Wound now probes to bone. x-ray at his convenience and with [provider's name] at next nue same treatment. Make es base of the wound. npletely fill the space but not on't stuff." t, read "Wound clinic visit- eeper. Continue BID [twice e 2 x 2 [inch] gauze opened with Anasept wound cleanser, ound [wound on buttock area] biscontinue Dakins 0.125% , x] weeks." dated July 15, 2022, through included the following entries				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED		
		33458	B. WING		12/	30/2022		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE				
CLADDAGH SENIOR LIVING 508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
01620	Continued From pa	ige 70	01620					
	he does not have a to wound clinic and -November 7, 2022 today. Dressing cha ordered." There was no evide assessments to inc R1's record. 90 DAY ASSESSM R1's 90 day assess for comprehensive	2, read "seen in wound clinic anges noted and supplies ence of routine wound clude measurements noted in						
	-dated June 3, 202 -dated June 27, 20 Notes, with comme administration dosa -dated August 25, 2 Notes, with comme 19, no other service -dated September Master Assessmen Assessment -post	ed the following assessments: 2, Client Monitoring Visit Notes 22, Client Monitoring Visit ent "Adjustment for insulin age." 2022, Client Monitoring Visit ent, "[R1] positive for COVID es needed at this time." 12, 2022, [licensee name] t, Change of Condition hospitalization. 0, 2022, Client Monitoring Visit ent, "[R1] states he's feeling						
	indicated "documer completed no more previous visit" and for housekeeping, p bathing, med remin other topics; are all	Ionitoring Visit Notes sheet ntation for client must be than 90 days from the included "services reviewed" personal hygiene, dressing, iders, med administration and home care services being rely; nursing assessment						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/	12/30/2022	
IAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, S				
LADDA	GH SENIOR LIVING		ICKOW AVENU DNIA, MN 5592				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE	
01620	Continued From pa	age 71	01620				
	revised; care plan/s	services appropriate for the					
	clients needs; are t	the services appropriate to the					
		nt/family problem, concerns, or					
		ised staff present; family					
	•	Documentation by RN-B on the					
		א" (no) was circled for response nent was revised. The sheets	3				
		d evidence of physical					
		by RN-B and comprehensive					
	review of all require	ed content.					
	CHANGE IN CONI	DITION ASSESSMENTS					
		an RN comprehensive					
		change in condition and					
	Condition Assessm	d content with a Change in nent.					
	R1's record include	ed nurses notes with the					
	following entries:						
		entry read, [R1] states to this					
		ing good. He feels like a cold is	S				
		energy level is down. Temp					
		blood pressure (B/P)-145/79, , respiratory rate (RR)-20,					
		ations- 92% on room air (RA).					
		clear, He complains of a dry					
		d for Covid 19 and results are					
		as been called to his provider.					
		entry read "Still not feeling well	-				
		st performed and he is now					
		bositive for COVID-19. He ld. O2 sats 96%, no temp,					
		ates "I feel okay, just no					
		port to provider. Awaiting to					
	hear back.						
		2, read [R1] is complaining of					
		nd burning with urination. After	r				
		is morning he had an emesis					
		37.6 degrees C, HR-94 and 4, RR-20, O2 saturation levels					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01620	Continued From pa	ge 72	01620			
	His family is called. him to urgent care.	to urgent care for evaluation. His sister [name] will escort Then entry read at 19:00 hospitalized for a UTI (Urinary	,			
	September 12, 202 Patient admitted wi returned growing E bowel). CT (compu images taken at dif and uses a comput images), showing e form of urinary trac characteristic of ga (bladder wall). Trea ceftriaxone and tran compete 7 day cou jardiance (diabetes (discontinuation), o risk of UTI, trulicity due to nausea/vom of medications but	s within the bladder and lumen ited with IV (intravenous) insitioned to oral cefdinir to rse. Of note, recently started injection), and favor d/c f jardiance given increased recently discontinued prior iting. Likely will need titration acutely d/c. Follow-up with provider) to monitor glucose				
	25, 2022, with com 19, no other service licensee's RN failed	sing assessment for a change				
	September 12, 202 upon his discharge					

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STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING.			
		33458	B. WING		12/	30/2022
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
01620	Continued From pa	age 73	01620			
	medication, seasor any of the allergies threatening; (3) infectious condi (4) a review of med Minnesota Statutes 2, including prescri medications, and s (a) the reason take (b) any side effects adverse reactions, issues; (c) the dosage; (d) the frequency o (e) the route admin (f) any difficulties the medication; (i) interventions need the resident or othe the medications; and (j) provide instruction resident's legal or of interventions to may medications; (6) a review of any therapist, occupation therapist, or cognition 12 months; (7) weight; M. risk indicators, i (3) complex medications	status, including: ensitivities related to hality, and environment and if or sensitivities are life itions; dications according to s, section 144G.71, subdivision ptions, over-the-counter upplements, and for each: en; s, contraindications, allergic or and actions to address these of use; histered or taken; he resident faces in taking the eded in management of vent diversion of medication by ers who may have access to and ons to the resident and designated representatives on anage the resident's revent diversion of reports from a physical onal therapist, speech ive evaluations within the last ncluding:				
presota De	due to personal los (6) unsuccessful pr	sses;				

STATE FORM

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED 12/30/2022	
		33458	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
	AGH SENIOR LIVING		OKOW AVENU			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01620	resident, including: (1) the presence of directive or other le a substitute decision (2) the scope of dec substitute decision O. the need for follo medical or cognitive On December 29, 2 nurse (RN)-B verifi nurse's notes to inc and wound conditio wound at least wee [licensed practical r dressing. I will need RN-B confirmed the Condition assessme completed with R1's lacked the required verified the licensee Notes" were used a tool and lacked the comprehensive RN R2 R2's diagnoses incl diabetes mellitus, c prostatic hyperplasi incontinence with pi catheter, mild mem due to venous insuf R2's Service Plan A 2022, included dres assistance, medica	any advance health care gal document that establishes n maker; and cision-making authority of a maker under subitem (1); and ow-up referrals for additional e care by health professionals. 2022, at 2:30 p.m. registered ed she had not written weekly dude wound measurements n and stated she "saw R1's kly, for a while the LPN hurse] and I were doing the d to write my notes better." e content of the Change of ent should have been s COVID-19 infection and content. Additionally, RN-B e's "Client monitoring Visit as the RN 90 day Assessment required content of a assessment. uded basal cell carcinoma, hronic kidney disease, benign a, and urinary urge resence of indwelling urinary ory disturbance, lymphedema fficiency. addendum dated August 22, asing, bathing, toileting tion management, blood theter assistance, insulin			Τ)	

ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		- (X3) DATE SURVEY COMPLETED	
		33458	B. WING		12/30/2022	
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE AREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED T		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01620	Continued From pa	ge 75	01620			
	content for comprel	ments lacked the required nensive monitoring and review ented physical assessment of ime of review.				
- M M M M M M T ir o pft b o pro o o n s tria a	-dated May 30, 202 Notes -dated August 22, 2 Notes, with note, "C monitoring him. Ser	d the following assessments 2, Client Monitoring Visit 022, Client Monitoring Visit Client has COVID. We are vices will not change." 0, 2022, Client Monitoring Visit				
	indicated "documer completed no more previous visit" and i for housekeeping, p bathing, med remin other topics; are all performed adequat revised; care plan/s clients needs; are th clients needs; client comments; unlicens member present. D sheets identified "N to nursing assessm lacked documented	onitoring Visit Notes sheet thation for client must be than 90 days from the ncluded "services reviewed" bersonal hygiene, dressing, ders, med administration and home care services being ely; nursing assessment services appropriate for the the services appropriate for the tranily problem, concerns, or sed staff present; family ocumentation by RN-B on the " (no) was circled for response ent was revised. The sheets I evidence of physical by RN-B and comprehensive id content.				
	R2's record lacked	DITION ASSESSMENTS a comprehensive RN change in condition with a and following a				

STATEMENT	a Department of He OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF PF	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE	•	
			CKOW AVENU			
CLADDAG	<b>SH SENIOR LIVING</b>	CALEDO	NIA, MN 5592	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
01620	Continued From pa	ge 76	01620			
	remain high and res name]. [R2] has a c COVID-19 and he is precautions in place -dated August 23, 2 with services delive precautions continu (temperature) today 93%, B/P- 103/67. Is sicker in my life." Ge Breath sounds are of daughter [name]. -dated August 29, 2 nurse today. He had insertion. Not a lot of to say his catheter If low and he had an e he's transported to His family are notifie -dated August 30, 2 possible UTI and lor -dated September 6 hospital today. He's responded well to tr Foley cath (catheter R2's Client Monitori 22, 2022, indicated the licensee's RN fa Comprehensive Ass Condition. R2's hospital discha September 6, 2022, included: patient's b returned with pan-si Patient was deemed discharge back to h	<ul> <li>a. His family is notified.</li> <li>022, [R2] has been in his apt. red to him. Standard</li> <li>e for COVID-19. Temp</li> <li>v is 36.8, HR-81, O2- sats</li> <li>He states "I've been a lot</li> <li>ot a dry non productive cough.</li> <li>clear. Report called to his</li> <li>022, Catheter change done by</li> <li>d a lot of discomfort with</li> <li>of output. Tonight staff called</li> <li>nas no drainage. His B/P is</li> <li>emesis. Ambulance called and</li> <li>[hospital name] for evaluation.</li> <li>ed.</li> <li>022, [R2] is hospitalized for</li> <li>w blood pressure.</li> <li>2022, [R2] returned from</li> <li>doing well and has</li> <li>reatment in the hospital. His</li> <li>r) was changed in the hospital.</li> <li>ng Visit notes dated August</li> <li>R2 had COVID-19; however,</li> </ul>				

OF CORRECTION	IDENTIFICATION NUMBER:				E SURVEY PLETED	
	33458	B. WING		12/30/2022		
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
GH SENIOR LIVING						
(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE	
Continued From pa	ige 77	01620				
Urology and his PC	P (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.						
obstructive sleep a blockage during sle hypertrophy (a thick main pumping char disorder, generalize back pain, hyperter early onset Alzheim	pnea (intermittent airflow eep), left ventricular kening of the wall of the hearts mber), major depressive ed anxiety, chronic bilateral low nsion, essential tremor, and ner's dementia (progressive					
2022, included asset transfers, wheeling toileting, medication "add to Med [medic plan", behavior mor housekeeping and spot/safety checks,	essments, dressing, bathing, , continence assist with n administration, treatments cation]/Tx [treatment]/Therapy nitoring or intervention, linens, personal laundry, oral care, activities escort,					
	GH SENIOR LIVING SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa Urology and his PC The licensee's RN Comprehensive As Condition related to On December 29, 2 verified the licensee Notes" were used a tool and lacked the Comprehensive RN "No, probably not d completing a Comp Change in Condition hospitalization. R3 R3's diagnoses inc obstructive sleep a blockage during sle hypertrophy (a thick main pumping char disorder, generalized back pain, hyperter early onset Alzheirr mental deterioration under age 65). R3's Service Plan A 2022, included assi transfers, wheeling toileting, medication "add to Med [medic plan", behavior mod housekeeping and spot/safety checks, nail care assistance	ROVIDER OR SUPPLIER       STREET ADD         GH SENIOR LIVING       508 KRUC CALEDON         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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 safe	B. WING	B. WING         STREET ADDRESS, CITY, STATE, ZIP CODE         GM SENIOR LIVING       STREET ADDRESS, CITY, STATE, ZIP CODE         GM SENIOR LIVING       STREET ADDRESS, CITY, STATE, ZIP CODE         GM SENIOR LIVING       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       IPROVIDER'S PLAN OF         (EACH DEFICIENCIES       IPROVIDER'S PLAN OF         (Continel A TOP OF CONTORING NOTOR) <td colspan<="" td=""><td>12/       ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       GB SENICR LIVING       SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SPECILL (EACH CORRECTIVE ACTION SPECILL)       ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SPICILL REGULATORY OR LISC IDENTIFYING INFORMATION)       DEPRETX TAG       ONTOTION OF LISC IDENTIFYING INFORMATION)       PRETX TAG       ONTOTION OF CORRECTION (EACH CORRECTIVE ACTION SPICIL)       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 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), let 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 Alzheimers' dementia (progressive mental deterioration which occurs in someone under age 65).       R3's Service Plan Addendum dated August 4, 2022, included assessments, dressing,</td></td>	<td>12/       ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       GB SENICR LIVING       SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SPECILL (EACH CORRECTIVE ACTION SPECILL)       ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SPICILL REGULATORY OR LISC IDENTIFYING INFORMATION)       DEPRETX TAG       ONTOTION OF LISC IDENTIFYING INFORMATION)       PRETX TAG       ONTOTION OF CORRECTION (EACH CORRECTIVE ACTION SPICIL)       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 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), let 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 Alzheimers' dementia (progressive mental deterioration which occurs in someone under age 65).       R3's Service Plan Addendum dated August 4, 2022, included assessments, dressing,</td>	12/       ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       GB SENICR LIVING       SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SPECILL (EACH CORRECTIVE ACTION SPECILL)       ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SPICILL REGULATORY OR LISC IDENTIFYING INFORMATION)       DEPRETX TAG       ONTOTION OF LISC IDENTIFYING INFORMATION)       PRETX TAG       ONTOTION OF CORRECTION (EACH CORRECTIVE ACTION SPICIL)       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.       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	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		12/	OULULL
CLADDA	AGH SENIOR LIVING		NIA, MN 5592			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN O(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO DEFICIEN		TION SHOULD BE	(X5) COMPLET DATE		
01620	Continued From pa	ge 78	01620			
01620	Management Plan or referenced in R3's S indicated "statement will be provided (cha- "blood glucose mont (continuous positive that uses mild airwa airways open while R3's assessment for August 4, 2022, ide assistance needed applicable]; no skin or monitoring". R3's record lacked of comprehensive nur- with development of (size, appearance, or On December 28, 2 observed to have he ULP-D stated R3 who R3 has "sores on bo stated R3 "kicks the At 9:16 a.m., observ ULP-D revealed an place on the outer s was intact on right he evaluator a box of Of faces foam and bor dressing) on R3's b ULP-D stated, "We tubes of Thera hone debridement; remov wound) was observ sink countertop. UL	dated August 4, 2022, (as Service Plan Addendum) at of the type of services that eck all that apply)" included hitoring" and "CPAP" e airway pressure) (a machine ay pressure to keep breathing				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01620	Continued From pa	ge 79	01620			
	R3 "developed the started on Hospice" when the blister dev were implemented. physician was notifi "measured the blist Hospice RN (RN-G lately looked at" R3 stated, "I have seer stated, "[RN-G] stat the treatment for th On December 28, 2 stated Hospice sup wear on heels. RN (licensed practical r on left heel two time changed almost da because gets rubbe wound on left heel bed [dead tissue the healthy skin after at and sloughed off". wound was "light ul pressure, stage one blanchable redness over a boney promi one month to disap treatment for R3's I and dry the wound wound bed and app R3's record identifie R3's left heel press -Notes dated Augus a blister on her left and are taking care -Notes dated Augus	2022, at 12:20 p.m. RN-G plied foam booties for R3 to -G further stated "me or LPN" nurse) assessed R3's wound es a week and "PRN gets ily by the ULP [facility staff] ed off". RN-G stated R3's when first noticed was "eschar at eventually sloughs off of n injury), Thera honey applied RN-G stated R3's left heel ceration some sort, likely e (intact skin with non s of a localized area usually nence). It took eschar about pear". RN-G stated the eft heel wound was "cleanse bed, apply Thera honey on the oly Optifoam 3 X 3" dressing. ed the following information for ure ulcer wound: st 9, 2022, R3 "has developed heel. Hospice is aware of it				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01620	Continued From pa	age 80	01620			
	description: unstag heel. Current meas [centimeters] X [by] wound cleanser, pa surrounding edges cover with 3 x 3 Op assess 2 X [two tim PRN [as needed] a R3's record lacked comprehensive ass wound to left heel v	ed November 3, 2022, "order eable pressure ulcer to the left sures on 11/3/2022 of 1.7 cm ] 1 cm X 0 cm. Cleanse with at dry, apply barrier cream to of eschar tissue and then otifoam, [Hospice] RN to nes] weekly and change and s needed by facility staff". documented evidence of sessment of pressure ulcer with development, including assessment to include size,				
	appearance, odor, o On December 29, 2 and RN-B stated th verbal communicat	drainage and pain. 2022, at 12:30 p.m. LALD-A ley were "not aware there was ion about it" from Hospice in ity staff assisting with R3's				
	for comprehensive	sments lacked required conten monitoring and review, lacked cal assessment of the resident nd lacked accurate				
	-dated December 1 Visit Notes -dated March 7, 20 Notes -dated June 1, 2022	ed the following assessments: 10, 2021, Client Monitoring 22, Client Monitoring Visit 2, Client Monitoring Visit Notes 022, Client Monitoring Visit				
nesota D	-dated August 4, 20 condition epartment of Health	022, assessment for change of				

STATE FORM

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If continuation sheet 81 of 165

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
01620	Continued From pa	ge 81	01620		,	
	-	, 2022, Client Monitoring Visit				
	lacked documented the following: B. activities of daily (1) toileting pattern D. physical health s (2) allergies and se medication, season any of the allergies threatening; (3) infectious condit (4) a review of med Minnesota Statutes 2, including prescrip medications, and st (a) the reason takes (b) any side effects adverse reactions, i issues; (c) the dosage; (d) the frequency of (e) the route admin (f) any difficulties th medication; (i) interventions nee medications to prev the resident or othe the medications; ar (j) provide instruction resident's legal or do interventions to ma medications; (6) a review of any therapist, occupation	status, including: nsitivities related to vality, and environment and if or sensitivities are life tions; ications according to , section 144G.71, subdivision otions, over-the-counter upplements, and for each: n; , contraindications, allergic or and actions to address these f use; istered or taken; re resident faces in taking the eded in management of vent diversion of medication by ers who may have access to ad ons to the resident and lesignated representatives on nage the resident's				

STATE FORM

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/30/2022	
		33458	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01620	Continued From pa	ge 82	01620			
	due to personal los (6) unsuccessful pr N. who has decision resident, including: (1) the presence of directive or other le a substitute decision (2) the scope of dec substitute decision O. the need for follo medical or cognitive	ation regimen; al or psychological distress ses; ior placements; n-making authority for the any advance health care gal document that establishes				
	indicated "documer completed no more previous visit" and i for housekeeping, p bathing, med remin other topics; are all performed adequat revised; care plan/s clients needs; are t clients needs; clien comments; unlicens member present. D sheets identified "N to nursing assessm lacked documented	htation for client must be than 90 days from the included "services reviewed" bersonal hygiene, dressing, iders, med administration and home care services being ely; nursing assessment services appropriate for the he services appropriate for the he services appropriate to the t/family problem, concerns, or sed staff present; family bocumentation by RN-B on the " (no) was circled for response nent was revised. The sheets d evidence of physical by RN-B and comprehensive				
	condition dated Aug page 18 RN-B docu the resident diabeti	sessment for change of gust 4, 2022, identified on umented "No" response for "Is c and did not identify R3 ar check once weekly. R3's				

STATEMEN	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED		
		33458	B. WING		12/20/2022			
NAME OF	PROVIDER OR SUPPLIER		B. WING 12/30/2022					
	GH SENIOR LIVING	508 KRU	ICKOW AVENU DNIA, MN 5592	JE NORTH				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE		
01620	Continued From pa	age 83	01620					
	assessment of diag	assessment lacked accurate documentation for assessment of diagnosis of diabetes and requiring blood sugar check.						
	and RN-B reviewed stated, "We will add not "explicit" with a have that" in the as facility's master ass required content fo completed a physic at the time the asse did not document the RN-B confirmed the documented evider R3. RN-B verified F condition dated Aug	2022, at 12:30 p.m. LALD-A d R3's assessments and d that", the assessment was reas required or "we don't sessment, regarding the sessment lacked the above r review. RN-B stated she cal assessment of the resident essments were completed, but he information. LALD-A and e assessments lacked nce of physical assessment of R3's assessment for change of gust 4, 2022, lacked accurate v for diabetes and blood sugar	f					
		documented evidence of nitoring and review for						
	discharged from th returning. She has changes and will st occupational/physic -Discharge Summa 2022, indicated sta diagnoses recurrer -Emergency Room dated July 20, 2022 21, 2022, Duricef (a	h 3, 2022, R3 will be e hospital today and be had a couple of medication cart having cal therapy. ary hospital dated March 3, ble for discharge and ht falls. (ER) After Visit Summary 2, indicated start taking on July antibiotic) 2 capsules (1,000 es daily for five days for	,					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		33458	3458 B. WING		12/	12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
01620	Continued From pa	ige 84	01620				
	-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						
	and RN-B reviewed assessments comp verified there were and review reasses above changes in o "I usually would, I n confirmed the asse was a regular sche evaluator requested	2022, at 12:30 p.m. LALD-A d R3's record and bleted as noted above. RN-B no comprehensive monitoring ssments completed for the condition for R3. RN-B stated, nay have missed". RN-B ssment dated March 7, 2022, duled 90 day assessment. The d R3's facility progress notes y 30, 2022, through July 25,					
	stated, "We can't fi referring to R3's "N	2022, at 10:49 a.m. LALD-A nd notes for those dates" otes" documented by staff for May 30, 2022, and July 25,					
		documented review for nd implementation of to fall.					
	R3's Incident Cente	er report dated December 16,					

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01620	2022, at 7:25 p.m. i "After helping aide were walking back 112 [R3] was laying Called other aides f over and back in ch reaching for someth we sat resident up of pressure, temperate Resident didn't com [manager on call] a her back into her ch room." December 1 RN-B, check R3 ov signs (blood pressurespiration) were do R3's Notes dated D R3 slipped out of B area. The worker as other staff person a for any injuries. Nor Vitals (blood pressurespirations) were do R3's record lacked conducted assessin factors, including in	ndicated fall unwitnessed. put another resident to bed we and noticed that the resident face down on her floor. for back up to get her turned hair. [R3] said she was hing and toppled over. When on floor took her vitals (blood ure, oxygen saturation, pulse). aplain of any pain. MOC nd RN called. Staff assisted hair with no issue. Resident's 6, 2022, documented by er. No injuries observed. Vital ure, temperature, heart rate, boumented. Recember 16, 2022, indicated roda chair onto floor in sitting ssisted her back into chair with assisting also. Checked over ne observed. Hospice notified. ure, pulse, temperature, documented. evidence the RN had hent of the fall for causative aplementation of interventions sative factors to minimize the				
	On December 30, 2 stated, that was "all had" for R3's fall as	2022, at 9:20 a.m. LALD-A the documentation the facility noted above.				
	Monitoring policy da the initial nursing as must include all the	essments, Reviews, and ated July 27, 2022, indicated ssessment or reassessment elements of the uniform required, conducted in				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		33458		B. WING		12/20/2022		
	PROVIDER OR SUPPLIER		B. WING         12/30/2022           DDRESS, CITY, STATE, ZIP CODE         12/30/2022					
	AGH SENIOR LIVING	508 KRU(	CKOW AVENU NIA, MN 5592	IE NORTH				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
01620	person (unless see signed by the regis assessment. Resid must be conducted in the needs of the	#2), be in writing, dated, and tered nurse who conducted the ent monitoring and review as needed based on changes resident and cannot exceed from the date of the last review. ion was provided.	01620					
01640 SS=D	that services are fir facility shall finalize (b) The service plan include a signature facility and by the re agreement on the s service plan must b resident reassessm facility must provide about changes to th and how to contact Long-Term Care. (c) The facility mus services required b (d) The service plan must be entered in including notice of a when applicable.	d revisions to d revisions to d calendar days after the date st provided, an assisted living a current written service plan. In and any revisions must or other authentication by the esident documenting services to be provided. The be revised, if needed, based on nent under subdivision 2. The e information to the resident the facility's fee for services the Office of Ombudsman for t implement and provide all y the current service plan. In and the revised service plan to the resident record, a change in a resident's fees	01640					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
			CKOW AVENU			
LADDA	GH SENIOR LIVING	CALEDO	NIA, MN 5592	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
01640	Continued From pa	age 87	01640			
	by: Based on observat review, the licenser resident's (R3) serv the current service This practice result violation that did no safety but had the resident's health or cause serious injur was issued at an is limited number of r a limited number of situation has occur The findings includ R3's diagnoses inc and early onset Alz (progressive menta someone under ag R3's Service Plan A 2022, indicated R3	ted in a level two violation (a ot harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and solated scope (when one or a residents are affected or one or f staff are involved or the red only occasionally). le: sluded Type 2 diabetes mellitus theimer's dementia al deterioration which occurs in the 65). Addendum dated August 4, received services including				
	wheeling, continen medication adminis Med [medication]/T plan", behavior mo housekeeping and spot/safety checks	sing, bathing, transfers, ce assist with toileting, stration, treatments "add to Tx [treatment]/There [therapy] nitoring or intervention, linens, personal laundry, , oral care, activities escort, e and safety assistance call				
	Management Plan referenced in R3's	Treatment or Therapy dated August 4, 2022, (as Service Plan Addendum) nt of the type of services that				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	L	DRESS, CITY, ST			00/2022
	FROVIDER OR SUFFLIER		CKOW AVENU			
CLADDA	AGH SENIOR LIVING		NIA, MN 5592			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
01640	Continued From pa	ge 88	01640			
	"blood glucose mor for testing the conc sugar) in the blood) positive airway pressur open while you slee R3's assessment for August 4, 2022, ind needing treatment of physical assist of tw out of bed/toileting, grooming, required hygiene/nail care an	eck all that apply)" included hitoring" (use of glucose meter entration of glucose (main and "CPAP" (continuous ssure) (a machine that uses re to keep breathing airways ep). or change of condition dated licated no skin concerns or monitoring. R3 required vo for transfers/getting in and was independent with physical assist with oral nd needed frequent redirection entation to person, place or				
	stated staff dressed hours with change used an EZ stand ( R3 could brush her	2022, at 3:00 p.m. ULP-D I R3, toileted R3 every three of incontinent product, staff mechanical lift) to transfer R3, own teeth with assist to set up staff comb R3's hair.				
	personnel (ULP)-D medications to R3 v chair (a positioning to have heel protec stated R3 wore the has "sores on botto stated R3 "kicks the At 9:16 a.m., obser ULP-D revealed an place on the outer s was intact on right I evaluator a box of 0 faces foam and bor	2022, at 8:14 a.m. unlicensed was observed to administer who was seated in a Broda wheelchair). R3 was observed tors on both feet. ULP-D heel protectors because R3 or of feet on heels". ULP-D em off every once in a while". vation of R3's heels with adhesive dressing was in side of R3's left heel. R3's skin heel. ULP-D showed the Dptifoam gentle EX silicone rder dressings (absorbent vathroom sink countertop.				

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING:			
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	GH SENIOR LIVING	508 KRU0	CKOW AVENU	JE NORTH		
CLADDA	GH SENIOR LIVING	CALEDO	NIA, MN 5592	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01640	Continued From pa	ge 89	01640			
01040	ULP-D stated, "We tubes of Thera hon- debridement; remo wound) was observ sink countertop. UL apply the Thera hon- heel and Hospice a On December 28, 2 nurse (RN)-B stated left heel after [R3] s shoes prior and wh "heel protectors" we the Hospice physici she had "measured with the Hospice RI "had not lately look RN-B stated, "I hav RN-B stated, "I hav RN-B stated, "I hav RN-B stated, "IRN- care of the treatme On December 28, 2 stated Hospice sup wear on heels. RN or LPN" (licensed p wound on left heel get's changed almod staff] because get's R3's wound on left "eschar bed [dead to off of healthy skin a applied and slough- heel wound was "lig pressure, stage one	[the ULP] put on heel". Two ey gel (promotes natural val of dead tissue from a red on top of R3's bathroom .P-D stated the night shift ULP ney gel and dressing to R3's pplied on R3's shower day. 2022, at 9:20 a.m. registered d R3 "developed the blister to started on Hospice". R3 wore en the blister developed the ere implemented. RN-B stated ian was notified. RN-B stated ian was notified. RN-B stated if the blister in the beginning" N (RN-G). RN-B stated she ed at" R3's wound on left heel. e seen it, not measured it." G] stated Hospice would take in for the left heel blister". 2022, at 12:20 p.m. RN-G plied foam booties for R3 to -G stated Hospice nurse "me tractical nurse) assessed R3's two times a week and "PRN ost daily by the ULP [facility a rubbed off". RN-G stated heel when first noticed was tissue that eventually sloughs ifter an injury), Thera honey ed off". RN-G stated R3's left ght ulceration some sort, likely e [intact skin with non s of a localized area usually				
	one month to disap treatment for R3's I	nence]. It took eschar about pear". RN-G stated the eft heel wound was "cleanse bed, apply Thera honey on the				
		bly Optifoam 3 X 3" dressing.				
innesota D	epartment of Health		μ			1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		33458	B. WING		12/30/2022		
NAME OF	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE	
01640	Continued From pa	ge 90	01640				
	R3's left pressure u -Notes dated Augus a blister on her left and are taking care -Notes dated Augus here to see [R3]. D [Hospice] RN." -Hospice order date description: unstag heel. Current meas [centimeters] X [by] wound cleanser, pa surrounding edges cover with 3 x 3 Op assess 2 X [two tim PRN [as needed] a R3's Care Tracking identified staff were services of activitie full assist, bathing f intervention, dressi laundry, medication care assist, CPAP a toileting assistance R3's service plan la of assistance with t to left heel pressure grooming-assist wit mobility, orientation person, place, time socialization/group On December 29, 2 assisted living direct they were "not awa	st 9, 2022, R3 "has developed heel. Hospice is aware of it of it." st 11, 2022, "Hospice services ressing done to heel by ed November 3, 2022, "order eable pressure ulcer to the left ures on 11/3/2022 of 1.7 cm 1 cm X 0 cm. Cleanse with at dry, apply barrier cream to of eschar tissue and then tifoam, [Hospice] RN to nes] weekly and change and s needed by facility staff". Sheet dated December 2022, e signing for providing the s escort, ambulation/transfer full assist, behavior ng full assist, housekeeping, a assist, nail care assist, oral assist, safety assistance, and whereabouts check. acked revision for the service reatments of dressing change e wound/heel protectors, th hair care, positioning, bed i-assist with orientating to , meals and and individual . 2022, at 12:30 p.m., licensed ctor (LALD)-A and RN-B stated					

Minneso	ota Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE
01640	Continued From pa	ge 91	01640			
	changes to left heel heel pressure wour protectors were treat LALD-A and RN-B r and Individualized T R3's service plan lat dressing change to protectors, groomin positioning, bed mo orientating to perso socialization/group The licensee's Serv 2022, indicated "ser needed, based on r monitoring." A servit description of the servite	vice Plan policy dated July 27, rvice plans, shall be revised, if resident reassessments and ce plan would include a ervices that are to be provided recent assessment and ss.				
	TIME PERIOD FOF Twenty-One (21) da					
01650 SS=F	144G.70 Subd. 4 (f and revisions to	) Service plan, implementation	01650			
	the fees for service, service, according to assessment and re- (2) the identification who will provide the (3) the schedule and assessments of the	the services to be provided, s, and the frequency of each to the resident's current sident preferences; of staff or categories of staff services; d methods of monitoring				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/	12/30/2022	
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CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
01650	Continued From pa	ge 92	01650				
	cannot be provided (ii) information and facility; (iii) the names and the resident wishes emergency or if the change in the resid- identification of and authority to sign for and (iv) the circumstand medical services ar consistent with cha declarations made chapters.	lan that includes: aken if the scheduled service ; a method to contact the contact information of persons to have notified in an re is a significant adverse ent's condition, including information as to who has the resident in an emergency ces in which emergency re not to be summoned pters 145B and 145C, and by the resident under those					
	by: Based on observati review, the licensee	ent is not met as evidenced on, interview and record a failed to ensure the service quired content for three of , R2, R3).					
	violation that did no safety but had the p resident's health or widespread scope ( or represent a syste	ed in a level two violation (a t harm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all					
	The findings include	e:					
		o include diabetes mellitus (a at affects the way the body					

STATE FORM

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		KOW AVENU NA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01650	processes blood su sacral pressure inju (an infection/inflami prostatic hyperplasi symptoms (enlarge urinary tract infection (inflammation of the affecting arteries in blindness). R1's Service Plan A 14, 2022, indicated include medication checks, wound care On December 28, 2 personnel (ULP)-F with medication adr check, and wound of R1's Service Plan A following: -the schedule and r assessments of the time frame for initia R2 R2's diagnoses incl diabetes mellitus, c prostatic hyperplasi incontinence with p catheter, mild mem due to venous insuf R2's Service Plan A 2022, indicated he f dressing, bathing, to management, blood	Igar (glucose), stage four iny with history of osteomyelitis mation in the bone), benign a with lower urinary tract prostate resulting in recurrent ons, and giant cell arteritis e lining of the arteries, often the head which can result in addendum dated September R1 received services to administration, blood glucose e and daily safety checks. 2022, at 8:15 a.m. unlicensed was observed to assist R1 ministration, blood glucose care. addendum lacked the methods of monitoring e resident (lacked accurate l assessment). uded basal cell carcinoma, hronic kidney disease, benign a, and urinary urge resence of indwelling urinary ory disturbance, lymphedema	01650			

ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
	33458	B. WING		12/	30/2022
PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
GH SENIOR LIVING			-		
SUMMARY STA		-		CORRECTION	(X5)
FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE	COMPLET DATE
Continued From page 94		01650			
indicated ULP prov daily blood glucose administration inclu catheter care to inc and catheter site clu assistance, and ass R2's Service Plan following: - the schedule and assessments of the time frame for initia R3 R3's diagnoses incl (a chronic condition processes blood su Alzheimer's demen deterioration which 65).	ided services to include twice checks, medication ding insulin injections, urinary lude urinary bag management eansing, dressing, and bathing sistance with transfers. addendum lacked the methods of monitoring e resident (lacked accurate l assessment). uded Type 2 diabetes mellitus n that affects the way the body ugar) and early onset tia (progressive mental occurs in someone under age				
2022, indicated R3 assessments, dress wheeling, continent medication adminis Med [medication]/T plan", behavior more housekeeping and spot/safety checks, nail care assistance pendant. R3's Individualized Management Plan referenced in R3's indicated "statement	received services including sing, bathing, transfers, ce assist with toileting, tration, treatments "add to x [treatment]/There [therapy] nitoring or intervention, linens, personal laundry, oral care, activities escort, e and safety assistance call Treatment or Therapy dated August 4, 2022, (as Service Plan Addendum) nt of the type of services that				
	OF CORRECTION PROVIDER OR SUPPLIER AGH SENIOR LIVING SUMMARY STA (EACH DEFICIENCY) REGULATORY OR L Continued From pa On December 28, 2 indicated ULP prov daily blood glucose administration inclu catheter care to inc and catheter site clu assistance, and ass R2's Service Plan a following: - the schedule and assessments of the time frame for initia R3 R3's diagnoses incl (a chronic condition processes blood su Alzheimer's demen deterioration which 65). R3's Service Plan A 2022, indicated R3 assessments, dress wheeling, continent medication adminis Med [medication]/T plan", behavior mon housekeeping and spot/safety checks, nail care assistance pendant. R3's Individualized Management Plan referenced in R3's indicated "statemen	OF CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         33458         STREET AL         GOVIDER OR SUPPLIER       STREET AL         SUMMARY STATEMENT OF DEFICIENCIES         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         REGULATORY OR LSC IDENTIFYING INFORMATION)         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,         add catheter site cleansing, dressing, and bathing         Service Plan addendum lacked the	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         33458       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST         SGH SENIOR LIVING       508 KRUCKOW AVENU CALEDONIA, MN 5592         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 94       01650         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 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) indicate	OF CORRECTION     IDENTIFICATION NUMBER:     A BUILDING:       33458     B. WING       GH SENIOR LIVING     STREET ADDRESS, CITY, STATE, ZIP CODE       SUMMARY STATEMENT OF DEFICIENCIES     508 KRUCKOW AVENUE NORTH       CALEDONIA, MN 55921     D       SUMMARY STATEMENT OF DEFICIENCIES     ID       REGULATORY OR LSC IDENTIFYING INFORMATION)     D       Continued From page 94     01650       On December 28, 2022, at 8:30 a.m. ULP-F     (EACH DERCORCENCE)       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's diagnoses included Type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar) and early onset       Alzheiner's dementia (progressive mental deterioration which occurs in someone under age 65).       R3's Service Plan Addendum dated August 4, 2022, (abcted R3 received services including, assessments, dressing, bathing, transfers, wheeling, continence assist with toileting, medication administration, treatments "add to Med (medication)TX (treatmentlyThere [therapy] plan", behavior monitoring or intervention, housekeeping and linens, personal laundry, spot/safety checks, oral	OF CORRECTION     IDENTIFICATION NUMBER:     A BUILDING:     12/       33458     B. WING     12/       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     508 KRUCKOW AVENUE NORTH       CALEDONIA, MN 55921     CALEDONIA, MN 55921     PROVIDER'S PLAN OF CORRECTION SHOULD BE       WING     ID     PREPRIZENCE TO THE PRECEDED BY FULL     PREPRIX       Continued From page 94     01650     CROS-REFERENCE TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL     CROS-REFERENCE TO THE APPROPRIATE DEFICIENCY       Continued From page 94     01650     01650     CROS-REFERENCE TO THE APPROPRIATE DEFICIENCY       On December 28, 2022, at 8:30 a.m. ULP-F     Tindicated ULP provided services to include twice daily blood gluccose checks, medication 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's diagnoses included Type 2 diabets mellitus (a chronic condition that affects the way the body processes blood sugar) and early onset     R3's Service Plan Addendum dated August 4, 2022, indicated R3 received services including assessments, dressing, bathing, transfers, wheeling, continence assist with toileting, medication/Tx (trament)/There (therapy)]       Plan", behavior monitoring or intervention, housekeeping and linens, personal laundry, spot/safety checks, orat care, activities escort, nail care assistance and safety assistance call pendant.       R3's I

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CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORREREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERE				
01650	sugar) in the blood) positive airway pressur open while you slee plan indicated for "r schedule Initial with "advanced directive medical services" h On December 27, 2 stated staff dressed hours with change used an EZ stand ( R3 could brush her and reminder and s On December 28, 2 observed to admini was seated in a Bro wheelchair). R3 wa protectors on both the heel protectors bottom of feet on he them off every once observation of R3's adhesive dressing of R3's left heel. R3 heel. ULP-D showe Optifoam gentle EX border dressings (a bathroom sink cour [the ULP] put on he gel (promotes natur dead tissue from a of R3's bathroom si the night shift ULP	and "CPAP" (continuous ssure) (a machine that uses re to keep breathing airways ep). In addition, the service monitoring and reassessment in 5 days" and the box next to es/POLST state no emergency		DEFICIENCY			

	NT OF DEFICIENCIES	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN (EACH DEFICIENCY MUST BE PRECEDED BY FULL       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE A       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO			ION SHOULD BE	(X5) COMPLETI DATE
01650	Continued From pa	ge 96	01650			
	started on Hospice' when the blister dev were implemented. physician was notifi "measured the blist Hospice RN (RN-G lately looked at" R3 stated, "I have seer stated, "[RN-G] stat the treatment for th On December 28, 2 stated Hospice sup wear on heels. RN or LPN" (licensed p wound on left heel the	2022, at 12:20 p.m. RN-G plied foam booties for R3 to -G stated Hospice nurse "me ractical nurse) assessed R3's two times a week and "PRN ost daily by the ULP [facility				
	following: - description of serv - assist with hair ca mobility, wound car orientating to perso socialization/group - the fees for servic service (grooming - positioning and bed orientation - assist place, time, meals, individual). - the schedule and assessments of the time frame for initia - a contingency plan (iv) the circumstand	es and the frequency of each assist with hair care, mobility, wound care, with orientating to person, socialization/group and methods of monitoring resident (lacked accurate l assessment).				

STATE FORM

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING	B. WING		12/30/2022	
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CLADDA	GH SENIOR LIVING		NIA, MN 5592				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
01650	Continued From pa	ae 97	01650				
	consistent with char declarations made l chapters (lacked Ho indication of code s Resuscitate) and la living will or not). On December 29, 2 and RN-B stated the verbal communicati regarding the facility dressing changes to the left heel pressur and heel protectors Hospice. LALD-A an plan lacked the abo the assessment sch	beters 145B and 145C, and by the resident under those ospice service marked, lacked tatus (Full Code or Do Not cked indication if R3 had a 2022, at 12:30 p.m. LALD-A ey were "not aware there was on about it" from Hospice, y staff were assisting with R3's o left heel wound. RN-B stated re wound dressing changes were treatments ordered by nd RN-B verified R3's service ve content. LALD-A verified nedule for initial assessment licensee's service plan utilized					
	2022 indicated "serr needed, based on r monitoring". A servi description of the se based on the most resident preference provided, the freque provided, a schedul planned assessmer facility will support of care directive decis circumstances whe are not to be summ as care plan, assign documents may be understanding their	rice Plan policy dated July 27, vice plans, shall be revised, if esident reassessments and ce plan would include a ervices that are to be provided recent assessment and s, fees for the services to be ency of each service to be e and method for the next at or monitoring and how the documented resident health ions if any, including n emergency medical services oned. Other documents such ment sheets or other internal used to assist staff in daily assignments and tasks, s are not required and do not the convice plan.					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRE(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)				ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
01650	Continued From pa	ge 98	01650			
	No further informati	on was provided.				
	TIME PERIOD FOF Twenty-One (21) da					
01710 SS=F	144G.71 Subd. 3 In monitoring and reas	dividualized medication	01710			
	reassess the reside services as needed resident presents w	facility must monitor and ent's medication management under subdivision 2 when the rith symptoms or other issues ation-related and, at a				
	by: Based on observati review, the licensee reassessment of m services at a minim	ent is not met as evidenced on, interview, and record e failed to ensure edication management um annually included all three of three residents (R1,				
	violation that did no safety but had the p resident's health or widespread scope ( or represent a syste	ed in a level two violation (a t harm a resident's health or ootential to have harmed a safety) and was issued at a when problems are pervasive emic failure that has affected to affect a large portion or all				
	2021, with diagnose stage four sacral pr osteomyelitis (an in	on date of November 23, es including diabetes mellitus, essure injury with history of fection/inflammation in the tatic hyperplasia with lower				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		KOW AVENU			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
01710	Continued From pa	ge 99	01710			
	in recurrent urinary arteritis (inflammati	oms (enlarge prostate resulting tract infections, and giant cell on of the lining of the arteries, ries in the head which can				
	indicated R1 receiv	lated September 14, 2022, ed services to include tration, blood glucose checks, ily 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.					
	identified as a Char (post hospitalization assistance with ora to three times daily, one time daily. The another document f medications R1 was required content of include: - physical health sta - a review of medica Statutes, section 14 including prescription medications, and sta - the reason taken;	ated September 12, 2022, nge in Condition Assessment n), indicated R1 required ULP I medication administration up , and insulin injection by ULP assessment did not indicate to reference regarding s receiving and lacked the a medication review to atus, including: ations according to Minnesota 4G.71, subdivision 2, ons, over-the-counter upplements, and for each:				
	adverse reactions, issues; - the dosage; - the frequency of u - the route administ	and actions to address these se;				

STATE FORM

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ED BY FULL PREFIX (EACH CORRECTIVE A			(X5) COMPLET DATE
	01710       Continued From page 100         - interventions needed in management medications to prevent diversion of me the resident or others who may have at the medications; and         - provide instructions to the resident an resident's legal or designated represent interventions to manage the resident's medications and prevent diversion of medications;         R1's record lacked a medication reassed by the registered nurse (RN) conducted face-to-face with the resident, with the required content:         - documentation the assessment was conface-to-face with the resident; and -identification and review of indications medications, side effects, contraindicational allergic or adverse reactions, and actionaddress these issues					
	medications to prev the resident or othe the medications and resident and legal of on interventions to medications and pr medications. On December 29, 2	ns needed in management of vent diversion of medication by ers who may have access to d provide instructions to the or designated representatives manage the resident's event diversion of 2022, at 1:25 p.m. RN-B wed medications with the				
	pharmacist regardir effects. R2 R2 had an admission with diagnoses includiabetes mellitus, c prostatic hyperplasi	ng contraindications and side on date of August 12, 2021, uding basal cell carcinoma, hronic kidney disease, benign				

STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/	12/30/2022	
	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
LADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
01710	catheter, mild mem due to venous insu R2's assessment d of admission indication with medication add labeled Medication indicated R1 neede administration. In t Management, the c provided oral medic times daily. In the s Mellitus, under 1. Is answer "yes" was c injections, no option 1.b2. Fingerstick Bl insulin injections wa R2's Service Plan A 2022, indicated he	ated August 12, 2021, at time ated August 12, 2021, at time ated A2 required assistance ministration. In the section Assistance, the record ed assistance with medication the section labeled Medication document indicated ULP cation assistance up to three section labeled Diabetes as the resident diabetic? the circled. Under 1.b1. Insulin ns were circled, and under lood Glucose, option A. no	01710				
	and insulin injection R2's medication ad dated December 20 medications to inclu- diabetes (insulin inj gastrointestinal refil prostate, two for mi- two skin creams. On December 28, 2 indicated ULP prov- daily blood glucose	ministration record (MAR) 022, indicated he received ude three medications for jections), one for ux, one for cholesterol, one for ild pain, one for dry eyes, and 2022, at 8:30 a.m. ULP-F ided services to include twice checks, and medication					
	R2's record include Monitoring Visit No used as the 90 day	Iding insulin injections. Id a document named Client tes, the licensee indicated was assessment tool. The d one line to include "Med					

Minnesota Departme	nt of Health					
STATEMENT OF DEFICIEN AND PLAN OF CORRECTIO	· · /	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
	:	33458	B. WING		12/	30/2022
NAME OF PROVIDER OR S	UPPLIER	STREET A	DDRESS, CITY, SI	TATE, ZIP CODE		
			ICKOW AVENU			
CLADDAGH SENIOR	LIVING		ONIA, MN 5592			
		OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
		BE PRECEDED BY FULL TIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETE DATE
01710 Continued	From page 102	2	01710			
the heading completed August 22, medication indicate R2 Additionally assessmen document i receiving. required co include: -the identifie the residen - indications - the dosag - the dosag - the freque - the route a - any difficu medications the residen the medications the residen the medications medications R2's record by the RN of resident, wi -documenta face-to-face - identifications	p "Discussed". on the following 2022, and Nov assessments received insul , the document ts, did not referent is known to be a for medicating the m The document ntent of a med cation and revit is known to be a for medication ations, allergic to address the e; administered of lties the reside ons needed in many to others who to others who to others who to others who to others who to others who to not a mange and prevent divi- to address the est op revent divi- to revent divi- to not a mange and prevent of a for medication to not a mange a for medication a for medica	ts considered rence another hedications R2 was above lacked the ication assessment to ew of all medications e taking; ns, side effects, or adverse reactions, ese issues; r taken; ent faces in taking the management of version of medication by may have access to de instructions to the gnated representatives e the resident's diversion of				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/	12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
		508 KRU0	CKOW AVENU	JE NORTH			
CLADDA	GH SENIOR LIVING	CALEDO	NIA, MN 5592	21			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
01710	Continued From pa	ge 103	01710				
	<ul> <li>-identify intervention medications to previous the resident or other the medications and pre- resident and legal of on interventions to medications and pre- medications.</li> <li>On December 29, 2 R2's medication plas stated she would no overlooked. On Dece RN-B provided ano medication plan or information was pro- R3 R3 had an admission diagnoses including early onset Alzheim mental deterioration under age 65).</li> <li>R3's Service Plan A 2022, indicated R3 management.</li> <li>On December 28, 2 observed to admini R3's assessment for August 4, 2022, indi- medication administ preference in how to</li> </ul>	<ul> <li>ans needed in management of vent diversion of medication by vers who may have access to d provide instructions to the or designated representatives manage the resident's event diversion of</li> <li>2022, at 2:45 p.m. regarding an and assessment, RN-B eed to look, as it was likely cember 30, 2022, at 9:00 a.m. ther treatment plan but no assessment. No further by ided.</li> <li>an date of June 7, 2021, with g Type 2 diabetes mellitus and her's dementia (progressive in which occurs in someone</li> <li>Addendum dated August 4, received medication</li> <li>2022, at 8:14 a.m. ULP-D was ster medications to R3.</li> <li>br change of condition dated licated R3 required assist with stration and R3 had "No"</li> </ul>					
	indicated R3 was u medications safely administer oral med assessment did not	nable to self administer without assistance, staff would dications four times daily. The t reference another document st of medications R3 was					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/202	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01710	Continued From pa	ge 104	01710			
	required content for D. physical health s (4) a review of med Minnesota Statutes 2, including prescrip medications, and s (a) the reason take (b) any side effects adverse reactions, i issues; (c) the dosage; (d) the frequency of (e) the route admin (f) any difficulties the medication; (i) interventions need medications to previse the resident or othe the medications; and (j) provide instruction resident's legal or do interventions to ma medications; R3's Medication Re- indicated staff were- used for back pain, nausea and vomitin mild pain or fever, of movements, one for diabetes, two vitam Alzheimer's demen depression, and on R3's record lacked by the RN conductor resident, with the for	etatus, including: ications according to , section 144G.71, subdivision obtions, over-the-counter upplements, and for each: n; , contraindications, allergic or and actions to address these f use; istered or taken; le resident faces in taking the eded in management of vent diversion of medication by ers who may have access to ad ons to the resident and lesignated representatives on nage the resident's event diversion of ecord dated December 2022, e administering one medication two for constipation, one for ag, one for secretions, one for one for loose bowel r high cholesterol, one for in supplements, one for tia, one for anxiety, two for	×			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		33458	B. WING		12/	30/2022
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		ICKOW AVENU DNIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01710	Continued From pa	ige 105	01710			
	medications, side e allergic or adverse address these issue -identify intervention medications to prev the resident or othe the medications an resident and legal of on interventions to medications and pr medications. On December 29, 2 and RN-B verified F reassessment for the further verified the s	eview of indications for effects, contraindications, reactions, and actions to es ns needed in management of vent diversion of medication by ers who may have access to d provide instructions to the or designated representatives manage the resident's				
	Assessment Monito policy dated August providing medicatio licensee would hav an assessment to o management servio how the services w	lication Management bring and Reassessment t 1, 2021, indicated prior to on management services the e a registered nurse conduct determine what medication ces would be provided and ould be provided. The nced statue/rule 144G.71				
	No further informat	ion was provided.				
	TIME PERIOD TO	CORRECT- Seven (7) days.				
01730 SS=E	144G.71 Subd. 5 Ir management plan	ndividualized medication	01730			

STATEMEN	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
and plan	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		33458	B. WING		12/	30/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETI DATE
01730	Continued From pa	ge 106	01730			
	management servic must prepare and in written statement of services that will be facility must develo individualized medie each resident base assessment that m (1) a statement des management servic (2) a description of on the resident's ne diversion, and cons directions; (3) documentation of relating to the admi (4) identification of monitoring medicat medication refills ar (5) identification of tasks that may be personnel; (6) procedures for s nurse or appropriat when a problem ari management servic (7) any resident-spe documenting medic verifications that all as prescribed, and to prevent possible reactions. (b) The medication current and update changes.	ust contain the following: cribing the medication ces that will be provided; storage of medications based eeds and preferences, risk of istent with the manufacturer's of specific resident instructions nistration of medications; persons responsible for ion supplies and ensuring that re ordered on a timely basis; medication management lelegated to unlicensed staff notifying a registered e licensed health professional ses with medication ces; and ecific requirements relating to cation administration, medications are administered monitoring of medication use complications or adverse management record must be d when there are any nciliation must be completed				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		22450	B. WING		10	20/2022
	PROVIDER OR SUPPLIER	33458 STREET AF	DRESS, CITY, ST		12/	30/2022
	GH SENIOR LIVING	508 KRU	CKOW AVENU NIA, MN 5592	E NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01730	Continued From pa	ge 107	01730			
	professional, or aut medication manage	horized prescriber is providing ement.				
	by: Based on observati review, the licensee individualized medi	ent is not met as evidenced ion, interview and record e failed to ensure an cation management plan to content for three of three R3).				
	violation that did no safety but had the p resident's health or cause serious injury was issued at a pat limited number of ro than a limited numb	ed in a level two violation (a to tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death) and ttern scope (when more than a esidents are affected, more ber of staff are involved, or the red repeatedly; but is not ve).				
	The findings include	e:				
	stage four sacral pr osteomyelitis (an in bone), benign prost urinary tract sympto in recurrent urinary arteritis (inflammati	to include diabetes mellitus, ressure injury with history of fection/inflammation in the tatic hyperplasia with lower oms (enlarge prostate resulting tract infections, and giant cell on of the lining of the arteries, ries in the head which can				
		lated September 14, 2022, ed services to include stration.				
	On December 28, 2	2022, at 8:15 a.m. unlicensed				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		33458	B. WING		12/30/20	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
LADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01730	Continued From pa	age 108	01730			
		was observed to assist R1 ministration, blood glucose care.				
	dated November 29 administration by far medication by phar locked medication with special manufa [insulin injection] re- specific instructions the facility nurse is supplies and orderid delegated to ULP: on nurse notification of to contact the licen questions or conce administration; doc medications are loc of medications administration ordered are located medications to previous of the second medications to previous of the second medication of the	Medication Management Plan 5, 2022, indicated "medication acility staff; Set-up of macist; medications stored in room; there are medications acturer's instructions: Basaglar equires refrigeration; client s: takes medications whole; responsible for monitoring ng refills; medications oral, subcutaneous [injection]; f problems or concerns: ULP sed nurse 24/7 with any rns with medication umentation related to cated on the MAR; verifications ninistered as prescribed or d on the MAR; monitoring of vent possible complications or can be found: on resident chart				
	dated December 20 include two for pros management, one cholesterol, one for two for heartburn, o	Iministration Record (MAR) 022, indicated medications to state, three for diabetes for water retention, one for heart health, one supplement one for wound healing, one for one for mild pain, and one	,			
	lacked identification tasks that may be o routes of: topical, e	Medication Management Plan n of medication management delegated to ULP to include the ye, inhalation and ear d parameters for antacid				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
01730	Continued From pa	ge 109	01730			
		the description of the in the locked medication cart.				
	record lacked the for -a description of stor the resident's needs diversion, and cons directions; -documentation of s relating to the admi -identification of me that may be delega On December 29, 2 nurse (RN)-B confir Medication Manage content. In reference parameters, RN-B s straight from the ph	medication management ollowing: orage of medications based on s and preferences, risk of istent with the manufacturer's specific resident instructions nistration of medications; and edication management tasks ted to unlicensed personnel. 2022, at 2:30 p.m. registered med R1's Individualized ement Plan lacked the required to the antacid dosing stated "this would have come systema of the required se for direction, this is a rare				
	diabetes mellitus, c prostatic hyperplasi incontinence with p	resence of indwelling urinary ory disturbance, lymphedema				
	2022, indicated he	ddendum dated August 22, received services to include ement, blood glucose checks, is.				
	dated December 20 medications to inclu	ministration record (MAR) 022, indicated he received ude three medications for astrointestinal reflux, one for				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/202	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
01730	Continued From pa	ge 110	01730			
		prostate, two for mild pain, nd 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.					
	plan/record and the (1) a statement des management servic (2) a description of on the resident's ne diversion, and cons directions; (3) documentation of relating to the admi (4) identification of monitoring medicat medication refills an (5) identification of tasks that may be of	an individualized medication e required content to include: scribing the medication ces that will be provided; storage of medications based eeds and preferences, risk of sistent with the manufacturer's of specific resident instructions nistration of medications; persons responsible for ion supplies and ensuring that re ordered on a timely basis; medication management delegated to unlicensed	3			
	nurse or appropriat when a problem ari management servic (7) any resident-spe documenting medic	ecific requirements relating to cation administration,				
	as prescribed, and to prevent possible reactions. (b) The medication	medications are administered monitoring of medication use complications or adverse management record must be				
	(c) Medication reco when a licensed nu	d when there are any changes nciliation must be completed rse, licensed health horized prescriber is providing ement.				

STATE FORM

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01730	Continued From pa	ge 111	01730			
	evaluator requested director (LALD)-A a include a Medicatio On December 29, 2 evaluator had not y Medication Plan to it probably was ove On December 30, 2 provided another co Treatment or Thera August 22, 2022, an requested. R3 R3's diagnoses incl and early onset Alzl (progressive menta someone under age R3's Service Plan A 2022, indicated R3 included medication On December 28, 2 observed to admini- obtained R3's medi medication cart whi medication room. U medications and pla applesauce prior to to R3. The medicati were vitamin B12 (u vitamin D3 capsule memantine (used for for depression), but	2022, at 2:45 p.m. the et received the requested which RN-B stated, "I will look, rlooked." 2022, at 9:00 a.m. RN-B opy of R2's Individualized py Management Plan dated nd not the Medication Plan as uded Type 2 diabetes mellitus neimer's dementia I deterioration which occurs in e 65). addendum dated August 4, received services which n management. 2022, at 8:14 a.m. ULP-D was ster medications to R3. ULP-D cations from a locked ch was located inside a locked ILP-D crushed a total of nine aced the medications in administering the medications ions observed to be crushed used to treat deficiency), (used for supplement), o treat Alzheimer's disease), anxiety), aripiprazole (used propion (used for depression), used for back pain), and				

Minnes	ota Department of He	alth			FORM	APPROVE
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		22450	B. WING		12/30/202	
		33458			12/	30/2022
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
CLADD	AGH SENIOR LIVING		KOW AVENU NIA, MN 5592			
						(1-)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE
01730	Continued From pa	ge 112	01730			
	dated August 4, 202 administration by fa stored in locked me medications with sp instructions for stor takes medications of responsible for mor refills on a timely ba medications that ma personnel; Nurse me problems/concerns nurse 24/7 with any medication adminis to medication adminis medication adminis medication adminis medication adminis medication sector administration reco to prevent possible reactions can be fo administration reco to prevent possible reactions can be fo administration reco R3's record/Individu Management Plan a resident specific ins medications (which crushed or not crus as needed (PRN) m constipation (Bisace plus); lacked parama administer for sche PRN hydromorphor administration of Pf lacked which PRN me pain/fever (Tylenol stablets); lacked des in medication cart; a	age; client specific instruction: whole; facility nurse is nitoring supplies and ordering asis; oral was marked for ay be delegated to unlicensed otification of ULP will contact the licensed r questions or concerns with tration; documentation related nistration are located: on the tration record; verification of stered as prescribed or I: on the medication rd; monitoring of medications complications or adverse und: on the medication rd." ualized Medication /Medication Record lacked structions for crushing medications should be hed); lacked parameters for nedication to use first for odyl suppository or senna neters for hours apart to duled hydromorphone and ne; lacked hours apart for RN loperamide medication; medication to use first for suppository or Tylenol oral coription of medication tasks ted to unlicensed personnel				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01730	Continued From pa	ge 113	01730			
01760 SS=D	record lacked the for -a description of stor the resident's needs diversion, and cons directions; -documentation of s relating to the admi -identification of me that may be delega On December 29, 2 and RN-B verified F LALD-A stated the p medication record f was entered on the the physician wrote LALD-A and RN-B for R3's medication the doctor about". F were to be "crushed on R3's medication medications could b No further information	brage of medications based on s and preferences, risk of istent with the manufacturer's specific resident instructions nistration of medications; edication management tasks ted to unlicensed personnel; 2022, at 12:30 p.m. LALD-A R3's record lacked the above. pharmacy creates the for the facility and whatever medication record was what for the medication order. stated regarding parameters s "something we will speak to RN-B stated R3's medications d" and there were no directions record indicating which be crushed or not crushed. CORRECT- Seven (7) days. ocumentation of				
	Each medication ac living facility staff m resident's record. T include the signatur administered the m must include the m	dministered by the assisted ust be documented in the he documentation must re and title of the person who edication. The documentation edication name, dosage, date red, and method and route of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY   AND PLAN OF CORRECTION 12/30/2022   33458 B. WING   NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CLADDAGH SENIOR LIVING   SUMMARY STATEMENT OF DEFICIENCIES ID   PROVIDER'S PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X2) ID PROVIDER'S PLAN OF CORRECTION (X5)	Minnesc	ota Department of He	alth			FORM	APPROVED
NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           CLADDAGH SENIOR LIVING         SUMMARY STATEMENT OF DEFICIENCIES         DB           OWIND TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH OENRECTIVE ACTION SHOULD BE cross-REFERENCED TO THE APPROPRIATE DEFICIENCY)         OWIND (EACH OORRECTIVE ACTION SHOULD BE cross-REFERENCED TO THE APPROPRIATE DEFICIENCY)           01760         Continued From page 114 administration. The staff must document the reason why medication administration was not completed as prescribed and ducument any follow-up procedures that were provided to meet the resident's medication was not administered as prescribed and in compliance with the resident's medication management plan.         01760           This MN Requirement is not met as evidenced by; Based on observation, interview, and record review, the ilconsee failed to ensure medications were administered as pre prescriber orders; failed to transcribe a medication order as written and failed to document, docage of a medication for one of three residents (R3).         This practice resulted in a level two violation (a violation that did not have harm are elident'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 dealth), and was issued at an isolated scope (when one or a limited number of staff are involved or the situation has occurred only occasionally).           The findings include: <th>STATEMEN</th> <th>IT OF DEFICIENCIES</th> <th>(X1) PROVIDER/SUPPLIER/CLIA</th> <th></th> <th></th> <th></th> <th></th>	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
Bit MORARY STATEMENT OF DEFICIENCES       IP PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY MUST BE PRECEDED BY FULL TAG       IP PROVIDER'S PLAN OF CORRECTION SHOULD be (EACH DEPICENCY MUST BE PRECEDED BY FULL TAG       IP PROVIDER'S PLAN OF CORRECTION SHOULD be (EACH DEPICENCY MUST BE PRECEDED BY FULL TAG       OUTPONT OF DEFICIENCY         01760       Continued From page 114       01760       DIFE       DEFICIENCY         01760       Continued From page 114       01760       DIFE       DEFICIENCY         01760       resident's nedication administration was not completed as prescribed and document the resident's needication administration 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 resident's need to hear a medication for one of three resident's need to 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 dealt), and was issued at an isolated scope (when one or a limited number of resident's 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,       Heat August 4,       Heat August 4,       Heat August 4,       Heat August 4,       <			33458	B. WING		12/3	30/2022
CLADDAGH SENOR LIVING     CALEDONIA, MN 55921       (74)10 PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY IPULL RECULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY IPULL RECULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PREFIX (EACH DEFICIENCY)     ID CACH DEFICIENCY)     PREFIX TAG     PREFIX (EACH DEFICIENCY)     ID CACH DEFICIENCY)     COMPLET DEFICIENCY)       01760     Continued From page 114     01760     01760     ID COMPLET TAG     ID CACH DEFICIENCY)     ID DEFICIENCY)     ID DEFICIENCY) <t< th=""><th>NAME OF</th><th>PROVIDER OR SUPPLIER</th><th>STREET AD</th><th>DRESS, CITY, S</th><th>TATE, ZIP CODE</th><th></th><th></th></t<>	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
(X4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PROVIDERS PLAN OF CORRECTION (EACH DEPICENCY MUST BE PRECEDED BY FULL TAG         PROVIDERS PLAN OF CORRECTION (EACH DEPICENCY MALTER DEPICIENCIES)         (X5) COMPLET TAG           01760         Continued From page 114         01760         Other 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 management plan.         01760           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 prescriber of a medication for one of three resident's nealication for one of three resident's nealication for one of three resident's nealication for alimited number of residents are affected or one or a limited number of residents are affected or 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,	CLADDA	GH SENIOR LIVING					
Přečrix TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRĚFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)       converter DEFICIENCY)         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 medication management plan.       01760         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 ofer one of three resident's (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 resident size 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,	(X4) ID	SUMMARY STA				ORRECTION	(X5)
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,	PRÉFIX			PREFIX	CROSS-REFERENCED TO TH	IE APPROPRIATE	COMPLETE
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 staff are involved or the situation has occurred only occasionally). The findings include: R3's Service Plan Addendum dated August 4,	01760	Continued From pa	ge 114	01760			
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		reason why medical completed as prese follow-up procedure the resident's needs administered as pre- with the resident's r This MN Requireme by: Based on observati review, the licensee were administered to transcribe a med failed to document one of three resider This practice result violation that did no safety but had the p resident's health or cause serious injury was issued at an is- limited number of re a limited number of situation has occurr The findings include R3's Service Plan A 2022, indicated R3 included medication On December 28, 2 personnel (ULP)-D medications to R3. medications and pla applesauce prior to	ation administration was not cribed and document any es that were provided to meet s when medication was not escribed and in compliance medication management plan. ent is not met as evidenced ion, interview, and record e failed to ensure medications as per prescriber orders; failed lication order as written and dosage of a medication for nts (R3). ed in a level two violation (a th harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or f staff are involved or the red only occasionally). e: Addendum dated August 4, received services which n management. 2022, at 8:14 a.m. unlicensed was observed to administer ULP-D crushed a total of nine aced the medications in administering the medications				
were vitamin B12 (used to treat deficiency) 1,000							

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		33458	B. WING		12/30/2	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01760	micrograms (mcg) international units ( memantine 5 millig Alzheimer's disease anxiety), aripiprazo for depression), bu depression), hydroi (used for back pain (used to treat diabe ADMINISTRATION R3's Medication Re 2022, included the -vitamin B-12 1,000 mcg) once daily -memantine 5 mg c -buspirone 10 mg c	two tablets; vitamin D3 5,000 IU) (used for supplement), rams (mg) (used to treat e), buspirone 10 mg (used for le 5 mg one half tablet (used propion 100 mg (used for morphone 2 mg one half tablet i), and metformin 500 mg etes).	01760			
	and December 28, -vitamin B-12 1,000 daily -memantine 5 mg t -buspirone 10 mg t -aripiprazole 5 mg t The licensee failed medications as per	prescriber's orders.	,			
	following: -loperamide 2 mg t loose bowel moven R3's prescriber ord included the followi	cember 2022, included the ake one capsule after each nent ers dated December 28, 2022	,			

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		33458	B. WING		12/30/2022		
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	DRESS, CITY, STATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU				
			NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE	
01760	Continued From pa	age 116	01760				
	as needed						
	R3's MR did not ma	atch 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						
	included the followi	ers dated December 28, 2022 ng: I-50 mg take one tablet daily	,				
	R3's MR lacked do plus.	cumented dosage for senna					
	assisted living direct nurse (RN)-B revier orders for medicati- lacked the above. prescriber orders w medications. LALD medication orders f LALD-A stated, "W up. I see the confus	2022, at 12:30 p.m. licensed ctor (LALD)-A and registered wed R3's MR and prescriber ons and verified R3's record RN-B verified the above vere R3's current orders for -A and RN-B stated all for R3 go through Hospice. e are going to have to follow sion" with Hospice regarding ers for medications.					
	2, 2022, at 6:17 p.r. have been reviewin you noted on interv [R3]. We are invest to let you know that was submitted to you received from hosp	from the licensee on January n. from LALD-A indicated "we ng the medication error that iew for patient with initials tigating this item and I wanted t the medication list/report that ou for review and which we sice is seemingly incorrect for a medication list from [R3's]					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/	2/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
LADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
01760	Continued From pa	ge 117	01760				
	However, we are de reconciliation review are on the same partypically only prescu- and the medication discrepancies are re- prescribes and wou- primary physician's spoke to said that t Hospice RN entere information based of Dr. Orders, but againvestigate this with pharmacy and per- currently shows that dosages at the time know when we have	w with Hospice to ensure they age. Hospice clarified that they ribe medications for comfort s where there are not ones that hospice typically and have continued off her orders. A hospice RN we here is a possibility that the d incorrect prescription on what is shown for current in, we are continuing to them. Our review with our [R3's] current doctors orders, at she received the correct of your review. I can let you e finalized the review, but I just how as you enter this					
	policy dated August was responsible for authorized prescrib treatments adminis file in the residents' would review all me for progress, effect regular basis and w condition. A resider						
	TIME PERIOD TO	CORRECT Source (7) doub					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			B. WING			
		33458			12/30/2022	
IAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
LADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
01790	Continued From pa	age 118	01790		,	
01790 SS=F	144G.71 Subd. 10 residents who will	Medication management for	01790			
	is not able to provid nurse or unlicensed medications in and the length of the ar exceed seven cale (3) the resident mu information on medi instructions for adm medications, includ (4) the medications medication contain the provider's medi- labeled with the res- and times that the (b) For unplanned to nurse is not available delegate this task th (1) the registered m unlicensed staff an staff is competent to giving medications (2) the registered m procedures for the including any speci- regarding controlle prescribed for the r address: (i) the type of conta- for the medications medication system (ii) how the contain labeled; (iii) written informati- be provided;	st be provided written dications, including any special ninistering or handling the ling controlled substances; and a must be placed in a er or containers appropriate to ication system and must be sident's name and the dates medications are scheduled. time away when the licensed ole, the registered nurse may o unlicensed personnel if: nurse has trained the d determined the unlicensed to follow the procedures for to residents; and nurse has developed written unlicensed personnel, al instructions or procedures d substances that are resident. The procedures must anner or containers to be used appropriate to the provider's				

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		12/	30/2022
			CKOW AVENU			
CLADDA	GH SENIOR LIVING	CALEDO	NIA, MN 5592	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01790	Continued From pa	ige 119	01790			
	provided, including medications were p medications, the per medications to the medications to the medications to the medications that we and other required (v) how the register medications have b registered nurse ne the medications are designated represe (vi) a review by the completion of this ta completed accurate personnel; and (vii) how the unlicer document in the res medications that ar including the name doses of each retur This MN Requirement by: Based on observation review, the licensee to develop written p management service away from home ar competency evaluation	ed nurse shall be notified that been provided and whether the eds to be contacted before e given to the resident or the intative; registered nurse of the ask to verify that this task was ely by the unlicensed nsed personnel must sident's record any unused e returned to the facility, of each medication and the med medication. ent is not met as evidenced ion, interview, and record e's registered nurse (RN) failed procedures for medication ces during unplanned times and failed to ensure training and				
	unlicensed personr This practice result violation that did no	required for two of two nel (ULP-F, ULP-D). ed in a level two violation (a ot harm a resident's health or potential to have harmed a				
	resident's health or widespread scope	safety) and was issued at a (when problems are pervasive emic failure that has affected				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		33458	B. WING	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
01790	Continued From pa	ge 120	01790				
	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.						
	assisted living direct nurse (RN)-B stated resident depending can do if they've be a written procedure ULP should know th staff meetings we c	2022, at 9:50 a.m. licensed ctor (LALD)-A and registered d, "We send a list with the on the number of days. Staff en trained." Regarding having , RN-B stated, "We do, the ne policy/procedure. During cover different topics." With the f needing to demonstrate stated, "ok."					
	RN provided trainin to prepare and adm residents for unplar ULP-D	ked evidence to indicate the g and determined competency ninister medications to nned times away. ate of August 31, 2022.	/				
	On December 28, 2 observed to admini 9:16 a.m., ULP-D s out, we put medicat with the family". UL write on the envelop med name is, time ULP-D stated "no c record or other info	2022, at 8:14 a.m. ULP-D was ster medications to R3. At tated when a resident "goes tions in an envelope and send P-D further stated the staff pe "whose they are, what the to give and staff initials". opy" of a resident's medicatior rmation was sent with the JLP-D stated sending,					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/30/2022		
IAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
LADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
01790	-	-	01790				
	RN provided training and determined competency to prepare and administer medications to residents for unplanned times away.						
	RN-B stated regard developed a writter management servin away from home for ULP, "if knew ahea LALD-A and RN-B do" regarding send who leave the facili have anything outs written procedure of ULP to follow for th administration of m unplanned times av reviewed ULP-D's of ULP-D lacked docu and determined co	2022, at 9:28 a.m. LALD-A and ding the licensee's RN in procedure for medication ces during unplanned times or delegation to the licensee's ad we do set up of meds". stated, "Yeah, they [ULP] can ing medications with residents ity. LALD-A stated, "We don't ide of policy" regarding a leveloped by the RN for the ne delegated task of nedications to residents for way. LALD-A and RN-B employee record and verified umented evidence for training mpetency to prepare and tions to residents for way.					
	Services policy dat registered nurse or may delegate tasks competent and pos consistent with the according to the ap act. When the regis professional delega	egation of Assisted Living ed August 1, 2021, read a licensed health professional s only to staff who are seess the knowledge and skill complexity of the tasks and propriate Minnesota practice stered nurse or licensed health ates tasks to ULP, that person or to the delegation the ULP is					
	trained in the prope tasks or procedure to demonstrate the	er methods to perform the s for each resident and is able ability to competently follow d perform the tasks.					
	No further informat	ion was provided.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		33458	B. WING		12/30/2022	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LADDA	GH SENIOR LIVING		ICKOW AVENU DNIA, MN 5592			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
01790	Continued From pa	ge 122	01790			
	TIME PERIOD FOF days	R CORRECTION: Seven (7)				
01880 SS=E	144G.71 Subd. 19 \$	Storage of medications	01880			
	substantially constru according to the ma	acility must store all tions in securely locked and ucted compartments anufacturer's directions and red personnel to have access.				
	by: Based on observati review, the licensee medication refrigera temperature to ensu stored according to recommendations in (2nd floor). Addition	n one of three refrigerators ally, the licensee failed to were securely stored for one				
	violation that did no safety but had the p resident's health or cause serious injury was issued at a pat limited number of re than a limited numb	ed in a level two violation (a t harm a resident's health or ootential to have harmed a safety, but was not likely to y, impairment, or death) and tern scope (when more than a esidents are affected, more per of staff are involved, or the red repeatedly; but is not we).				
	The findings include	9:				
	On December 27, 2	2022, at 11:00 a.m. during				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01880	Continued From pa	age 123	01880			
	stated medications stored in mini refrig medication rooms ( of the assisted livin unit). On December 28, 2	ce, registered nurse (RN)-B requiring refrigeration were gerators in the locked (three total-one on each floor ig and one in the memory care 2022, at 12:45 p.m. the sensed personnel (ULP)-F				
	completed a review temperature of the the second floor of evaluator observed filled with ice/frost t multiple medication colder temperature a thermometer. UL noticed a thermom	v of the contents and mini-refrigerator located on the assisted living. The an open freezer compartment build up, which then exposed he housed in the refrigerator to es. The mini refrigerator lacked P-F stated she had never eter in the mini refrigerator and y system to track and monitor	I			
	included: -latanoprost eye dr. with storage recom Fahrenheit (F); -erythromycin 0.5% tube, with storage r degrees F; -basaglar 100 units pens, with storage degrees F; -novolog flex pen (i storage recommen	cond floor mini-refrigerator ops (for glaucoma), one bottle mendations 68-77 degrees beye ointment (antibiotic), one recommendations 59-86 s/milliliter (u/ml) (insulin), sever recommendations 36-46 insulin) 100 u/ml, one pen with dations 36-46 degrees F; and				
	storage recommen On December 29, 2 stated, "Typically th	mg/0.5 ml, 3 pens with dations 36-46 degrees F. 2022, at 1:00 p.m. RN-B he nurse puts the medications and the pharmacy tells us				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
01880	Continued From pa	ge 124 nedications. It is in the works,	01880				
	we have plans to do MEDICATIONS UN On December 28, 2 observed to admini- was seated in a Bro- wheelchair). At the apartment, a bottle treat types of fungu- medication was obs by R3's bed. ULP-D was used for R3 "fo ULP-D showed the tubes of medication sink. ULP-D stated Thera honey get to On December 28, 2 observed R3's apar	b." SECURED 2022, at 8:14 a.m. ULP-D was ster medications to R3 who oda chair (a positioning time of administration in R3's of Nystatin powder (used to s infections of skin) served to be located on a table 0 stated the Nystatin powder or folds belly". At 9:16 a.m., evaluator two Thera honey ge a located on R3's bathroom the night shift staff applied the R3's heel wound. 2022, at 9:20 a.m. RN-B tment with the evaluator.					
	there" regarding Th observed on R3's b regarding the Nysta	vice said it was okay to leave era honey gel two tubes athroom sink. RN-B stated atin powder bottle being stored bed "no it's not supposed to be					
	August 1, 2021, rea managed and store medications will be stored per manufac						
	No further informati						
	TIME PERIOD FOR days	R CORRECTION: Seven (7)					

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			- (X3) DATE SURVEY COMPLETED - 12/30/2022	
		33458	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLETE DATE
01890	Continued From pa	ge 125	01890			
01890 SS=E	144G.71 Subd. 20 I	Prescription drugs	01890			
	immediate or later a the original containe by the pharmacy be label with legible inf	prior to being set up for administration, must be kept in er in which it was dispensed earing the original prescription formation including the d-use date of a time-dated				
	by: Based on observati review, the licensee medications with an residents (R1, R6) a	ent is not met as evidenced on, interview, and record e failed to label time sensitive n opened date for two of two and failed to ensure labels on ers (house supply medicine)				
	violation that did no safety but had the p resident's health or cause serious injury was issued at a pat limited number of re than a limited numb	ed in a level two violation (a t harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death) and tern scope (when more than a esidents are affected, more per of staff are involved, or the red repeatedly; but is not ve).				
	The findings include	e:				
	On December 28, 2 evaluator and unlice reviewed the conter	MEDICATION CART 2022, at 12:30 p.m. the ensed personnel (ULP)-F nts of the second floor he assisted living building of				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		-	
		33458	B. WING		12/	30/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
01890	Continued From pa	ge 126	01890			
	opened date indicat -R1's basaglar 100 flex pen with recom days after opening; -R6's Ventolin HFA to discard 12 month foil pouch; -R6's incruse ellipta indicated discard si Additionally, a bottle (cough medicine) la lacked legible bottle On December 29, 2 nurse (RN)-B stated open dates on the v	units/milliliter (u/ml) insulin mendations to discard 28 inhaler with recommendations as after removing it from the 62.5 mg (inhaler) label x weeks after opening. e of siltussin expectorant abeled only as "house supply" e label instructions. 2022, at 1:00 p.m. registered d, "All staff are trained to write white sticker as the pharmacy				
	use." MEMORY CARE M The licensee failed	EDICATION CART to ensure date open for a eye d legible label for cough				
	observation of the r care unit with ULP- 0.005% eye drop m being used for adm bottle had a sticker	2022, at 9:05 a.m. during nedication cart in the memory D, a bottle of Latanoprost edication was opened and inistration to a resident. The for date opened; however, no ocumented. ULP-D verified				
	the findings. Two b (used to relieve cou other breathing illne faded labels making at the time. ULP-D	ottles of siltussin expectorant igh caused by common cold or esses) were observed to have g it unreadable. ULP-D verified stated when looking at the oked like it was "a resident's"				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		33458	B. WING	B. WING		30/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		ICKOW AVENU INIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01890	Continued From pa	age 127	01890			
	medication". ULP-	e looked like facility "stock D stated, "I think nurses" were ing checking medications for ication cart.				
	of the medication c should have date o medication". RN-B good to be used for stated the date on t sent from the pharr RN-B observed the expectorant medica	2022, at 9:25 a.m. observation art with RN-B stated, "Yes, pen for the eye drop stated the eye drops were r 30 days once opened. RN-B the eye drop label of being macy was November 1, 2022. two bottles of siltussin ation and stated "can't read uld "return to pharmacy" to be				
	Prohibition policy d when [licensee nam drug, prior to being administration, the in the original conta by the pharmacy be label with legible in	lications-Prescription Drugs & ated August 1, 2021, read ne] receives a prescription set up for immediate or later prescription drug must be kep ainer in which it was dispensed earing the original prescription formation including the d-use date of a time-dated				
	No further informat	ion was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01940 SS=D	144G.72 Subd. 3 Ir therapy manageme	ndividualized treatment or en	01940			
	ordered or prescrib	eceiving management of ed treatments or therapy ed living facility must prepare				

BBXB11

If continuation sheet 128 of 165

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
01940	Continued From pa	ge 128	01940			
	statement of the tree that will be provided must also develop a individualized treatr management record contain at least the (1) a statement of th provided; (2) documentation of relating to the treatr administration; (3) identification of the will be delegated to (4) procedures for r appropriate licensee problem arises with services; and (5) any resident-spe documentation of tr received, verification therapy was admini- monitoring of treatr possible complication therapy was admini- monitoring of treatr possible complication treatment or therapp be current and updat changes. This MN Requirement by: Based on observati- review, the licensee individualized treatr include all required residents (R1, R3). This practice result violation that did no	d for each resident which must following: he type of services that will be of specific resident instructions				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01940	Continued From pa	age 129	01940			
	was issued at an is limited number of r a limited number o	y, impairment, or death), and colated scope (when one or a esidents are affected or one or f staff are involved or the red only occasionally).				
	The findings includ	e:				
	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.					
	stage four sacral p osteomyelitis (an ir bone), benign pros urinary tract sympto in recurrent urinary arteritis (inflammat	to include diabetes mellitus, ressure injury with history of nfection/inflammation in the tatic hyperplasia with lower oms (enlarge prostate resulting tract infections, and giant cell ion of the lining of the arteries, ries in the head which can				
		dated September 14, 2022, ved services to include blood d wound-care.				
	2022, indicated a w (at the base of the to include: "depth: t cm [centimeters] le	r visit note dated April 15, yound location of "coccyxgeal" tailbone), with measurements full thickness; wound size: 4.2 ength X [by] 1.2 cm wide X 3.7 lerate exudate [wound				
	dated November 7	e] Dr. Appointment record , 2022, indicated a Wound note "Wound clean, but				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE. ZIP CODE	12/3	50/2022
CLADDA	GH SENIOR LIVING	508 KRUC	KOW AVENU	ENORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
01940	Continued From pa	ge 130	01940			
	2 X [by]2 gauze ope Anasept wound clea periwound, ABD [dr Follow up in six (6) R1's wound care in 2022, read A.M. and continue with dress Gently remove old co opened up and moi cleaner (switched b solution when the A out). 4. Apply petrol with ABD (absorber medipore tape (a ge	essing] and paper tape. weeks." structions dated November 8, d P.M. shift to complete. 1. ing changes twice daily. 2. dressing. 3. Use 2 X 2 gauze stened with Anasept wound ack to a diluted Dakins nasept wound cleaner ran eum around wound. 5. Cover at dressing) and affix with entle skin tape).				
	November 29, 2022 included the times of the designated time The ULP document following characteri amount, drainage c	ocumentation record dated 2, through December 1, 2022, of 9:00 a.m. and 5:00 p.m. as as for R1's dressing changes. ed information for the stics of the wound: drainage olor, wound bed color, signs ri area (other areas in the				
	dated June 27, 202 treatments to includ procedures for staff	therapy management plan 2, indicated R1 received le wound care, but lacked notifying a registered nurse s arose with the treatment of care.				
	verified R1's treatm for when ULP shou	2022, at 2:30 p.m. RN-B ent plan lacked the instruction Id notify her with concerns with eatment. RN-B stated she, und very often."				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/	12/30/2022	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
אחחא וי	GH SENIOR LIVING	508 KRU(	CKOW AVENU	E NORTH			
	SH SENIOR EIVING	CALEDO	NIA, MN 5592	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
01940	Continued From pa	age 131	01940				
	and early onset Alz	al deterioration which occurs in					
	2022, indicated R3 included "Treatmer signs daily or week airway pressure/a r pressure to keep b you sleep], blood g meter for testing th (main sugar) in the creams, insulin, etc [treatment]/There [t the service plan "Tr vital signs daily or v checks, wound car	Addendum dated August 4, received services which hts, including weights, vital ly, CPAP [continuous positive machine that uses mild airway reathing airways open while lucose checks [use of glucose e concentration of glucose blood], wound care, nebs, c. *Add to Med [medication]/Tx thera] plan". The statement on reatments, including weights, weekly, CPAP, blood glucose e, nebs, creams, insulin, etc. plan" was system wide for all ans.					
	Management Plan referenced in R3's indicated "statemen will be provided (ch "blood glucose mon for testing the cond sugar) in the blood positive airway pres	Treatment or Therapy dated August 4, 2022, (as Service Plan Addendum) nt of the type of services that neck all that apply)" included nitoring" (use of glucose meter centration of glucose (main ) and "CPAP" (continuous ssure) (a machine that uses re to keep breathing airways ep).					
	observed to admin was seated in a Browheelchair). R3 was protectors on both	2022, at 8:14 a.m. ULP-D was ister medications to R3 who oda chair (a positioning as observed to have heel feet. ULP-D stated R3 wore due to R3 has "sores on					

STATEME	ota Department of He NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CLADD	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
01940	bottom of feet on he them off every once observation of R3's adhesive dressing v of R3's left heel. R3 heel. ULP-D showe Optifoam gentle EX border dressings (a bathroom sink cour [the ULP] put on he gel (promotes natur dead tissue from a of R3's bathroom si the night shift ULP a dressing to R3's he R3's shower day. On December 28, 2 R3 "developed the started on Hospice' when the blister dev were implemented. physician was notifi "measured the blist Hospice RN (RN-G lately looked at" R3 stated, "I have seer stated, "Hospice [R take care of the treat On December 28, 2 stated Hospice sup wear on heels. RN- or LPN" (licensed p wound on left heel to get's changed almos staff] because get's R3's wound on left	ge 132 eels". ULP-D stated R3 "kicks e in a while". At 9:16 a.m., heels with ULP-D revealed an was in place on the outer side t's skin was intact on right d the evaluator a box of a silicone faces foam and bsorbent dressing) on R3's netrop. ULP-D stated, "We el". Two tubes of Thera honey ral debridement; removal of wound) was observed on top nk countertop. ULP-D stated apply the Thera honey gel and el and Hospice applied on 2022, at 9:20 a.m. RN-B stated blister to left heel after [R3] . R3 wore shoes prior and veloped the "heel protectors" RN-B stated the Hospice ed. RN-B stated she had er in the beginning" with the ). RN-B stated she "had not 's left heel wound. RN-B n it, not measured it." RN-B N-G] stated Hospice would atment for the left heel blister". 2022, at 12:20 p.m. RN-G plied foam booties for R3 to -G stated Hospice nurse "me ractical nurse) assessed R3's wo times a week and "PRN st daily by the ULP [facility rubbed off". RN-G stated heel when first noticed was issue that eventually sloughs	01940			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/3	30/2022	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
LADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE	
01940	Continued From pa	age 133	01940				
	heel wound was "lig pressure, stage on blanchable redness over a bony promir one month to disap treatment for R3's and dry the wound wound bed and ap R3's record identifi R3's left heel press -Notes dated Augu a blister on her left and are taking care -Notes dated Augu here to see [R3]. D [Hospice] RN." -Hospice order dat description: unstag heel. Current meas [centimeters] X [by wound cleanser, pa surrounding edges cover with 3 x 3 Op assess 2 X [two tin PRN [as needed] a R3's Individualized	st 9, 2022, R3 "has developed heel. Hospice is aware of it					
	referenced in R3's dated August 4, 20 type of services that	Service Plan Addendum) 22, indicated "statement of the at will be provided (check all					
	Mondays and CPA requirements relati instructions of treat	d blood glucose monitoring P; Resident specific ing to documentation and tment and therapy received is					
	electronic health re	dministration record (TAR), ecords (EHR/TAR)/Service ocedures for notifying a					

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/30/2022		
	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
			CKOW AVENU				
CLADDA	AGH SENIOR LIVING	CALEDO	NIA, MN 5592	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
01940	Continued From pa	age 134	01940				
	health professional treatments or thera registered nurse is or by phone for sta concerns with treat services; Verification therapy was admin treatment administre health records (EH record; monitoring prevent possible co reactions:treatment electronic health re charting record."	RN) or appropriate licensed when a problem arises with py management services: a available 24/7 either in person ff to report problems or ments or therapy managemen on that all treatments and istered as prescribed: ration record (TAR), electronic R/TAR)/Service charting of treatments or therapy to omplications or adverse t administration record (TAR), cords (EHR/TAR)/Service					
	October 17, 2022, 1	e sheet with dates from through December 26, 2022, ted blood glucose results y.					
	identified "Oxygen team shut off mach remove the headge nasal pillows and w warm soapy water. on clean towel. Sta warm water and so morning. PM team putting on mask for water chamber with line and turn mach performing hourly v	Sheet dated December 2022, Assistance Instructions AM ine, take mask off mask, ear straps, and wash out mask vater chamber (humidifier) with Rinse off and allow to air dry ff will wash out tubing with ap once weekly on Saturday staff will assist resident in r CPAP machine, staff will fill n distilled water to the "max" ine on at bedtime. When whereabouts checks after ensure that mask is on properly	,				

Minneso	ota Department of He	alth				APPROVE
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		33458	B. WING		12/	30/2022
	PROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, S		•	
CLADDA	AGH SENIOR LIVING		NIA, MN 5592			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
01940	Continued From pa	ge 135	01940			
	management recom- a statement of the provided (wound dr protectors); -documentation of s relating to the treatr administration (wou protectors); -identification of tre will be delegated to dressing changes, I -procedures for not appropriate license problem arises with services (paramete (high/low readings) heal protectors, CP -any resident-specie documentation of tr verification that all t administered as pre treatment or therap complications or ad dressing changes, I On December 29, 2 and RN-B verified F and therapy manag above. LALD-A and aware there was ve from Hospice, rega assisting with R3's wound. LALD-A sta for for blood glucos less than 60". LALE Sheet indicating Ox was a "software iss	atment or therapy tasks that unlicensed personnel (wound heel protectors); ifying a registered nurse or d health professional when a treatments or therapy rs for blood glucose check , wound dressing changes, AP); and fic requirements relating to reatment and therapy received reatment and therapy was escribed, and monitoring of y to prevent possible liverse reactions (wound				

	ota Department of He			CONSTRUCTION		
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE
01940	Continued From pa	ge 136	01940			
01950 SS=D	changes and heel p ordered by Hospice documenting for pro- dressing changes/h record lacked reside related to documen The licensee's Dele Services policy date the licensee's RN w specific instructions document those ins record. No further informati TIME PERIOD TO 0 144G.72 Subd. 4 A and therapy	pressure wound dressing protectors were treatments a. RN-B verified staff were not oviding the services of wound heel protectors to R3 and R3's ent-specific requirements tation of the treatments. egation of Assisted Living ed August 1, 2021, indicated yould specify in writing, a for each resident and structions in the resident's ion was provided. CORRECT- Seven (7) days. dministration of treatments	01950			
	must be administer other licensed healt perform the treatme delegated or assign the licensed health appropriate practice assignment. When or therapy is delega personnel, the facili registered nurse or professional has: (1) instructed the ur proper methods wit the unlicensed pers ability to competent	bed treatments or therapies ed by a nurse, physician, or th professional authorized to ent or therapy, or may be ned to unlicensed personnel by professional according to the e standards for delegation or administration of a treatment ated or assigned to unlicensed ity must ensure that the authorized licensed health h respect to each resident and sonnel has demonstrated the cly follow the procedures; ting, specific instructions for				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/	12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
01950	Continued From pa	age 137	01950				
	in the resident's rec (3) communicated	documented those instructions cord; and with the unlicensed personnel I needs of the resident.					
	by: Based on observat review, the licensed registered nurse (F specific instructions documented those records for one of t instructed the unlic proper methods wit two of two unlicens had demonstrated follow the procedur This practice result violation that did no safety but had the p resident's health or cause serious injur was issued at an is limited number of r a limited number of	ent is not met as evidenced ion, interview, and record e failed to ensure the RN) specified, in writing, s for each resident and instructions in the resident's hree residents (R3); had ensed personnel (ULP) in the th respect to each resident and ed personnel (ULP-F, ULP-D) the ability to competently res. red in a level two violation (a to tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or f staff are involved or the red only occasionally).					
	evidence the licens determined ULP-D administer the treat care and dressing of	s record lacked documented see had trained and and ULP-F were competent to tment service of R1's wound changes.					
	ULP-F had a hire d	ate of May 17, 2021.					
	R1						

STATE FORM

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. DOILDING.	·····		
		33458	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	GH SENIOR LIVING		CKOW AVENU			
		CALEDO	NIA, MN 5592	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE <sup>-</sup> DATE
01950	Continued From pa	age 138	01950			
	stage four sacral p osteomyelitis (an ir bone), benign pros urinary tract sympto in recurrent urinary arteritis (inflammat	to include diabetes mellitus, ressure injury with history of nfection/inflammation in the static hyperplasia with lower oms (enlarge prostate resulting tract infections, and giant cell ion of the lining of the arteries, ries in the head which can				
		dated September 14, 2022, /ed services to include blood d wound care.				
	personnel (ULP)-F with a blood glucos	2022, at 8:15 a.m. unlicensed was observed to assist R1 se check, and wound care to area at base of tailbone).				
	Plan (attachment to 15, 2022, indicated change to coccyx,	ent and Therapy Management o the Service Plan) dated April I the treatment of dressing to be done twice daily with both gement of dressing changes.				
	dated November 7 Clinic visit with the deeper. Continue E 2 x [by]2 gauze ope Anasept wound cle	ne] Dr. Appointment record , 2022, indicated a Wound note "Wound clean, but BID [twice daily] dressings-Use ened up and moistened with eanser, petroleum to ressing] and paper tape.				
	2022, read, A.M. and continue with dress Gently remove old [inch]gauze opened	nstructions dated November 8, nd P.M. shift to complete. 1. sing changes twice daily. 2. dressing. 3. Use 2 x 2 d up and moistened with eaner (switched back to a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		33458	B. WING	B. WING		12/30/2022		
	PROVIDER OR SUPPLIER		T ADDRESS, CITY, STATE, ZIP CODE					
			CKOW AVENU					
JLADDA	GH SENIOR LIVING	CALEDO	ONIA, MN 5592	1				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE		
01950	Continued From pa	age 139	01950					
	cleaner ran out). 4. wound. 5. Cover w	ition when the Anasept wound Apply petroleum around ith ABD (absorbent dressing) pore tape (a gentle medical						
	November 29, 202 the times of 9:00 a designated times for ULP documented i characteristics of the drainage color, wor	documentation record dated 2-December 1, 2022, included .m. and 5:00 p.m. as the or R1's dressing changes. The nformation for the following he wound: drainage amount, und bed color, signs of area (other areas in the groin)						
	"Training is usually multiple wound car	2022, at 9:50 a.m. RN-B stated done with staff as R1 has had e changes, but it's [training] nented. Will do in the future."						
	ULP-D had a hire o	date of August 31, 2022.						
	licensee had traine competent to admi	ked documented evidence the ad and determined ULP-D was nister the treatment service of anges and heel protectors for						
	2022, indicated R3 included "Treatmer signs daily or week airway pressure/a i pressure to keep b	Addendum dated August 4, received services which nts, including weights, vital kly, CPAP [continuous positive machine that uses mild airway reathing airways open while lucose checks [use of glucose						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		508 KRU	CKOW AVENL	JE NORTH		
LADDA	GH SENIOR LIVING	CALEDO	NIA, MN 5592	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
01950	Continued From pa	age 140	01950			
	(main sugar) in the	blood], wound care, nebs, *Add to Med [medication]/Tx				
	Management Plan referenced in R3's dated August 4, 20, type of services that that apply) included Mondays and CPAI requirements relati instructions of treat found: treatment ac electronic health re charting record; Pro- registered nurse (F health professional treatments or thera registered nurse is or by phone for sta concerns with treat services; Verification therapy was admin treatment administ health records (EH record; monitoring prevent possible co- reactions:treatment	Treatment or Therapy dated August 4, 2022, (as Service Plan Addendum) 22, indicated "statement of the at will be provided (check all d blood glucose monitoring P; Resident specific ng to documentation and ment and therapy received is dministration record (TAR), cords (EHR/TAR)/Service ocedures for notifying a RN) or appropriate licensed when a problem arises with py management services: a available 24/7 either in person ff to report problems or ments or therapy management on that all treatments and istered as prescribed: ration record (TAR), electronic R/TAR)/Service charting of treatments or therapy to omplications or adverse t administration record (TAR), cords (EHR/TAR)/Service				
	observed to have h ULP-D stated R3 w R3 has "sores on b stated R3 "kicks the At 9:16 a.m., obser ULP-D revealed an	2022, at 8:14 a.m. R3 was leel protectors on both feet. vore the heel protectors due to bottom of feet on heels". ULP-D em off every once in a while". vation of R3's heels with a adhesive dressing was in side of R3's left heel. R3's skin				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		ICKOW AVENU INIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01950	was intact on right l evaluator a box of ( faces foam and bor dressing) on R3's b ULP-D stated, "We tubes of Thera hon debridement; remo wound) was observ sink countertop. UL apply the Thera hon heel and Hospice a On December 28, 2 stated Hospice sup wear on heels. RN R3's left heel woun	heel. ULP-D showed the Optifoam gentle EX silicone rder dressings (absorbent bathroom sink countertop. [the ULP] put on heel". Two ey gel (promotes natural val of dead tissue from a ved on top of R3's bathroom .P-D stated the night shift ULP ney gel and dressing to R3's applied on R3's shower day. 2022, at 12:20 p.m. RN-G oplied foam booties for R3 to I-G stated the treatment for d was "cleanse and dry the Thera honey on the wound bed				
	assisted living direct they were "not awa communication abo the facility staff were changes to left hee heel pressure wour protectors were treat RN-B verified staff to R3. RN-B verified training and compe- licensee's ULP for I The licensee's Dele Services policy data when the registered	2022, at 12:30 p.m. licensed ctor (LALD)-A and RN-B stated re there was verbal out it" from Hospice, regarding re assisting with R3's dressing I wound. RN-B stated the left and dressing changes and heel atments ordered by Hospice. were applying heel protectors ed she had not provided etency to ULP-D or any of the R3's left heel wound treatment egation of Assisted Living ed August 1, 2021, indicated d nurse or licensed health ensee name] delegated tasks				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		KOW AVENU			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01950	•	-	01950			
	perform the tasks o and is able to demo	I in the proper methods to r procedures for each resident onstrate the ability to the procedures and perform				
	No further informati					
	TIME PERIOD TO	CORRECT- Seven (7) days.				
01960 SS=D	144G.72 Subd. 5 D administration of tre		01960			
	assisted living facili record. The docume signature and title of administered the tre include the date and treatment or therap ordered or prescribe document the reaso	eatment or therapy and must d time of administration. When ies are not administered as ed, the provider must on why it was not administered rocedures that were provided				
	by: Based on observati review, the licensee documentation of tr	ent is not met as evidenced on, interview, and record e failed to ensure eatments administered as hree residents (R2, R3).				
	violation that did no safety but had the p resident's health or cause serious injury was issued at an iso	ed in a level two violation (a t harm a resident's health or ootential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		ICKOW AVENU DNIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01960	Continued From pa	age 143	01960			
		f staff are involved or the red only occasionally).				
	The findings includ	e:				
		the documented time of he treatment service of blood				
	2022, indicated he medication manage	Addendum dated August 22, received services to include ement, blood glucose checks, e, and insulin injections.				
	Management Plan indicated the servic with resident specif documentation of t the Treatment Adm	Treatment or Therapy dated August 22, 2022, ce of blood glucose monitoring fic requirements relative to reatment and therapy found or inistration Record and c (EHR/TAR) Service Charting				
	indicated ULP prov daily blood glucose administration inclu	2022, at 8:30 a.m. ULP-F rided services to include twice e checks, medication uding insulin injections, urinary clude urinary bag management leansing.				
	2022, indicated, "S [R2's] blood glucos before bed. If readi than 60, notify the I The record indicate date, one for "Befo one for "Before Su	e record dated December pecific Instructions: Check ie levels before breakfast and ing is greater than 300 or less RN immediately." ed three columns: one for the re Breakfast/Staff Initials" and pper/Staff initials" where the blood glucose number and				

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	AGH SENIOR LIVING		CKOW AVENU			
CLADDA		CALEDO	NIA, MN 5592	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
01960	Continued From pa	ge 144	01960			
	their initials. The re day the blood gluco	cord lacked the times of the se was checked.				
	nurse (RN)-B and li (LALD)-A verified the glucose monitoring RN would update the information. R3 R3's record lacked title of the person we or therapy and the of for providing the tree wound dressing char addition, R3's record	2022, at 2:45 p.m. registered censed assisted living director he records lacked the time was completed and stated the he records to include this documented signature and who administered the treatment date and time of administration teatment services of left heel anges and heel protectors. In d lacked documented time of reatment service of blood				
	2022, indicated R3 included "Treatmen signs daily or week airway pressure/a n pressure to keep br you sleep], blood gl meter for testing the (main sugar) in the	Addendum dated August 4, received services which its, including weights, vital ly, CPAP [continuous positive nachine that uses mild airway reathing airways open while ucose checks [use of glucose e concentration of glucose blood], wound care, nebs, a. *Add to Med [medication]/Tx hera] plan".				
	Management Plan referenced in R3's dated August 4, 202 type of services tha that apply) included Mondays and CPAF requirements relating	Treatment or Therapy dated August 4, 2022, (as Service Plan Addendum) 22, indicated "statement of the t will be provided (check all blood glucose monitoring P; Resident specific ng to documentation and ment and therapy received is				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		— 12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01960	Continued From pa	age 145	01960			
		dministration record (TAR), cords (EHR/TAR)/Service				
		ecord dated December 2022, lite test strip use to test blood Monday".				
	October 17, 2022, identified documen documented weekl results of blood glu	e sheet with dates from through December 26, 2022, ted blood glucose results y and included the date and cose check. The sheet lacked lecked R3's blood glucose.				
	identified "Oxygen team shut off mach remove the headge nasal pillows and w warm soapy water. on clean towel. Sta warm water and so morning. PM team putting on mask for water chamber with line and turn mach performing hourly w	Sheet dated December 2022, Assistance Instructions AM nine, take mask off mask, ear straps, and wash out mask vater chamber (humidifier) with Rinse off and allow to air dry ff will wash out tubing with hap once weekly on Saturday staff will assist resident in r CPAP machine, staff will fill in distilled water to the "max" ine on at bedtime. When whereabouts checks after ensure that mask is on properly	,			
	R3's left heel press -Notes dated Augus a blister on her left and are taking care -Notes dated Augus	st 9, 2022, R3 "has developed heel. Hospice is aware of it				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED		
		33458	B. WING		12/30/2022			
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE				
CLADDAGH SENIOR LIVING 508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
01960	description: unstage heel. Current meass [centimeters] X [by] wound cleanser, pa surrounding edges cover with 3 x 3 Op assess 2 X [two tim PRN [as needed] as On December 28, 2 observed to have h ULP-D stated R3 w R3 has "sores on b stated R3 "kicks the At 9:16 a.m., obser ULP-D revealed an place on the outer s was intact on right f evaluator a box of C faces foam and bor dressing) on R3's b ULP-D stated, "We tubes of Thera hore debridement; remov wound) was observ sink countertop. UL apply the Thera hore heel and Hospice a On December 28, 2 RN (RN-G) stated H for R3 to wear on h nurse "me or LPN" assessed R3's wou week and "PRN get ULP [facility staff] b	eable pressure ulcer to the left ures on 11/3/2022 of 1.7 cm   1 cm X 0 cm. Cleanse with at dry, apply barrier cream to of eschar tissue and then tifoam, [Hospice] RN to nes] weekly and change and s needed by facility staff". 2022, at 8:14 a.m. R3 was eel protectors on both feet. ore the heel protectors due to ottom of feet on heels". ULP-D em off every once in a while". vation of R3's heels with adhesive dressing was in side of R3's left heel. R3's skin heel. ULP-D showed the Dptifoam gentle EX silicone rder dressings (absorbent bathroom sink countertop. [the ULP] put on heel". Two ey gel (promotes natural val of dead tissue from a ved on top of R3's bathroom .P-D stated the night shift ULP hey gel and dressing to R3's ipplied on R3's shower day. 2022, at 12:20 p.m. Hospice Hospice supplied foam booties eels. RN-G stated Hospice (licensed practical nurse) ind on left heel two times a ts changed almost daily by the recause get's rubbed off".		DEFICIENCY				
nnesota D	providing the treatm	documentation of staff nent service for left heel anges, heel protectors and the						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			-			
		33458	B. WING		12/	30/2022
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
LADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
01960	Continued From pa	ge 147	01960			
	time of day staff checked R3's blood glucose every Monday.					
	and RN-B stated the verbal communication regarding the facility dressing changes to the left heel pressure and heel protectors Hospice. RN-B verifi- protectors to R3. RI documenting for pro- dressing changes/h and RN-B verified F dates from October	2022, at 12:30 p.m. LALD-A ey were "not aware there was ion about it" from Hospice, y staff were assisting with R3's o left heel wound. RN-B stated re wound dressing changes were treatments ordered by fied staff were applying heel N-B verified staff were not oviding the services of wound heel protectors to R3. LALD-A R3's Blood Glucose sheet with 17, 2022, through December pocumented time of day staff I glucose.				
	Record-Documenta August 1, 2021, ind documented in the treatment/therapy re medication assistan the time, the quanti administration of all the counter medica treatments/therapy,	signature and title of the who provided the assistance on of ent/therapy.	,			
	TIME PERIOD TO	CORRECT- Seven (7) days.				
01970 SS=D	144G.72 Subd. 6 Ti	reatment and therapy orders	01970			
	There must be an u	un to data unittan an				1

STATE FORM

BBXB11

If continuation sheet 148 of 165

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
			CKOW AVENL			
CLADDA	GH SENIOR LIVING	CALEDO	NIA, MN 5592	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01970	Continued From pa	age 148	01970			
		electronically recorded order from an authorized prescriber for all treatments and therapies. The				
		the name of the resident, a				
	description of the tr	reatment or therapy to be				
		requency, duration, and other				
		t to administer the treatment on and therapy orders must be				
	renewed at least ev					
	This MN Requirem	ent is not met as evidenced				
	by:					
		ion, interview, and record				
	review, the licensee	e failed to ensure a for treatment or therapy for one				
	of three residents (					
	violation that did no safety but had the p resident's health or cause serious injur was issued at an is limited number of a limited number of	ted in a level two violation (a bit harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and colated scope (when one or a esidents are affected or one or f staff are involved or the red only occasionally).				
	The findings includ	e:				
	and early onset Alz	al deterioration which occurs in				
	observed to have h	2022, at 8:14 a.m. R3 was leel protectors on both feet. nel (ULP)-D stated R3 wore				
	the heel protectors	due to R3 has "sores on				
		eels". ULP-D stated R3 "kicks				
		e in a while". At 9:16 a.m., s heels with ULP-D revealed ar				
	epartment of Health	The Derevenier of the realed at	•			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	33458	B. WING		12/30/2022	
AME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	508 KRU	CKOW AVENU	IE NORTH		
LADDAGH SENIOR LIVING	CALEDO	NIA, MN 5592	1		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01970 Continued From page	ge 149	01970			
adhesive dressing w of R3's left heel. R3' heel. ULP-D showed Optifoam gentle EX border dressings (at bathroom sink count [the ULP] put on hee gel (promotes natura dead tissue from a v of R3's bathroom sin the night shift ULP a dressing to R3's hee R3's shower day. On December 28, 20 nurse (RN)-B stated left heel after [R3] st shoes prior and whe "heel protectors" we the Hospice physicia she had "measured with the Hospice RN "had not lately looke RN-B stated, "I have RN-B stated, "I have RN-B stated, "RN-G care of the treatmen On December 28, 20 stated Hospice supp wear on heels. RN- (licensed practical n on left heel two time changed almost dail because gets rubber wound on left heel w bed [dead tissue tha healthy skin after an and sloughed off". F	vas in place on the outer side s skin was intact on right d the evaluator a box of silicone faces foam and osorbent dressing) on R3's tertop. ULP-D stated, "We el". Two tubes of Thera honey al debridement; removal of vound) was observed on top nk countertop. ULP-D stated upply the Thera honey gel and el and Hospice applied on 022, at 9:20 a.m. registered R3 "developed the blister to carted on Hospice". R3 wore en the blister developed the re implemented. RN-B stated an was notified. RN-B stated the blister in the beginning" I (RN-G). RN-B stated she id at" R3's wound on left heel. e seen it, not measured it." stated Hospice would take t for the left heel blister". 022, at 12:20 p.m. RN-G blied foam booties for R3 to G stated "me or LPN" urse) assessed R3's wound s a week and "PRN gets y by the ULP [facility staff] d off". RN-G stated R3's when first noticed was "eschar it eventually sloughs off of injury), Thera honey applied RN-G stated R3's left heel teration some sort, likely				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING		12/	30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
01970	Continued From pa	age 150	01970				
	over a boney promi one month to disap treatment for R3's I and dry the wound wound bed and app R3's Service Plan A 2022, indicated R3 included "Treatmer signs daily or week airway pressure/a r pressure to keep by you sleep], blood g nebs, creams, insu [medication]/Tx [tree R3's Individualized	s of a localized area usually inence]. It took eschar about opear". RN-G stated the left heel wound was "cleanse bed, apply Thera honey on the oly Optifoam 3 X 3" dressing. Addendum dated August 4, received services which hts, including weights, vital ly, CPAP [continuous positive machine that uses mild airway reathing airways open while lucose checks, wound care, lin, etc. *Add to Med eatment]/There [thera] plan". Treatment or Therapy					
	referenced in R3's dated August 4, 20 type of services that that apply) included Mondays and CPAI requirements relating instructions of treat found: treatment ac electronic health re charting record".	dated August 4, 2022, (as Service Plan Addendum) 22, indicated "statement of the at will be provided (check all d blood glucose monitoring P; Resident specific ng to documentation and tment and therapy received is dministration record (TAR), ecords (EHR/TAR)/Service R3's service plan lacked the or left heel wound dressing protectors.					
	R3's left heel press -Notes dated Augus a blister on her left and are taking care -Notes dated Augus	st 9, 2022, R3 "has developed heel. Hospice is aware of it					

STATE FORM

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE	•	
CLADDA	GH SENIOR LIVING		NIA, MN 5592	-		
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLET DATE
				DEFICIENC	CY)	
01970	Continued From pa	ae 151	01970			
		9				
	R3's Care Tracking	P2's Caro Tracking Shaet dated December 2022				
	R3's Care Tracking Sheet dated December 2022, identified "Oxygen Assistance Instructions AM					
		ine, take mask off mask,				
		ar straps, and wash out mask	,			
	nasal pillows and w	ater chamber (humidifier) with				
	warm soapy water. Rinse off and allow to air dry					
		ff will wash out tubing with				
		ap once weekly on Saturday				
		staff will assist resident in				
		CPAP machine, staff will fill distilled water to the "max"				
		ne on at bedtime. When				
		vhereabouts checks after				
		nsure that mask is on properly	,			
	and machine is on.					
		documented evidence of a				
		or the treatment services of				
	protectors.	und dressing change and heel				
	protectors.					
	RN-B provided surv	veyor with the following				
		ion orders for R3, which were				
	faxed to the facility	on December 28, 2022 and				
	December 29, 2022					
		of "Dec. 28, 2022, at 9:47				
		ember 28, 2022 10:56 a.m."				
		d November 3, 2022, "order				
		eable pressure ulcer to the left				
		ures on 11/3/2022 of 1.7 cm 1 cm X 0 cm. Cleanse with				
		at dry, apply barrier cream to				
		of eschar tissue and then				
		tifoam, [Hospice] RN to				
		ies] weekly and change and				
		s needed by facility staff", with				
		f December 28, 2022, at 9:47	1			1

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		33458	B. WING		12/30/2022		
IAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
LADDA	GH SENIOR LIVING		ICKOW AVENU DNIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
01970	Continued From pa	age 152	01970				
	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.						
	stated, "Yesterday,	2022, at 12:20 p.m. RN-G they [the licensee] asked me for orders", regarding R3's left ng change.					
	assisted living direct they were "not awa communication about stated the left heel changes and heel porter applying heel proter R3's record lacked dressing change to protectors. RN-B si order for R3's CPA 9:20 a.m. RN-B pro- order and stated, ""	2022, at 12:30 p.m. licensed ctor (LALD)-A and RN-B stated re there was verbal but it" from Hospice. RN-B pressure wound dressing protectors were treatments a. RN-B verified staff were ctors to R3. RN-B verified a prescriber order for wound R3's left heel and for heel tated they would look for an P. On December 30, 2022, at pvided R3's CPAP prescriber Yesterday I called [R3's] did not have it, so I called the the order".					
	policy dated Augus was responsible fo authorized prescrib	dication and Treatment Orders t 1, 2021, indicated the RN r assuring that current, per orders for medications or stered by the staff are kept on ' records.					
	No further informat	ion was provided.					
	TIME PERIOD FOI days	R CORRECTION: Seven (7)					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
	PROVIDER OR SUPPLIER		DRESS CITY S	TATE, ZIP CODE		00/2022
CLADDA	AGH SENIOR LIVING		IIA, MN 5592			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
02110	Continued From pa	ige 153	02110			
02110 SS=F	144G.82 Subd. 3 P	olicies	02110			
	assisted living facili must develop and i procedures that add (1) philosophy of ho based upon the assivation values, mission, an person-centered car shall be implement (2) evaluation of be design of supports including nonpharm person-centered ar (3) wandering and o provides detailed in a resident elopes; (4) medication man assessment of resi of medications, incl medications; (5) staff training spe (6) description of fa efforts to keep the fa (8) limiting the use intercom systems fa evacuation drills on (9) transportation c and from outside m (10) safekeeping of (b) The policies and to residents and the	by services are provided sisted living facility licensee's id promotion of are and how the philosophy ed; shavioral symptoms and for intervention plans, nacological practices that are nd evidence-informed; egress prevention that instructions to staff in the event aggement, including an dents for the use and effects luding psychotropic ecific to dementia care; fe enrichment programs and mplemented; imily support programs and family engaged; of public address and or emergencies and				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		33458	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	-	
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
02110	Continued From pa	age 154	02110			
	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).					
	violation that did no safety but had the resident's health or widespread scope or represent a syste	ted in a level two violation (a ot harm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected I to affect a large portion or all				
	The findings includ	e:				
		o the licensee for assisted lovember 23, 2021.				
	R2 was admitted to living services on A	o the licensee for assisted august 12, 2021.				
		o the licensee June 7, 2021, ng assisted living services				
	documented evider residents' legal and received the writter	esident records lacked nce the residents and the d designated representatives n policies and procedures that 2 Subd. 3. at the time of lity.				
		dents Service Plan Addendum gnature for receipt on "page 7'				

	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
02110	Continued From pa	age 155	02110			
	a copy of the Disclo	nation for: "I have been offered osure of Special Care Unit, nentia training information".				
	Disclosure of Spec sheets undated, ind "disclosure, philoso [licensee name] me the assessment an plan, [licensee nam training, special car features, programs the special care un wellness program f	see's [licensee name] ial Care Unit information cluded information for ophy, criteria for residence in emory care, process used for d establishment of the service ne] staffing credentials and re unit design and security and activities for residents of it, our activity program, our family involvement, fee ional services to memory care				
	Disclosure of Spec sheets did not inclu living facility with de procedures as liste reference the polici resident and the re representatives: -3.02 ALDC Behav and Nonpharmalog 1, 2021; -3.03 ALDC Demen August 1, 2021; -3.05 ALDC Family 2021; -3.05 ALDC Life Er and Outdoor space -3.07 ALDC Medica August 1, 2021;	licensee's [licensee name] ial Care Unit information ude the licensee's assisted ementia care policy and d below, or specifically ies as being provided to the sidents' legal and designated ioral Symptoms, Interventions gical Approaches dated August ntia Care Philosophy dated r Support dated August 1, michment Programs, Activities e dated August 1, 2021; ation Management dated of Dementia Training dated				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		33458	B. WING	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
CLADDA	GH SENIOR LIVING		ICKOW AVENU INIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
02110	Continued From pa	ge 156	02110				
	August 1, 2021; -3.12 ALDC Use of 2021;	August 1, 2021; ortation Coordination dated Intercom dated August 1, ering and Elopement dated					
	assisted living direct residents signed for care unit", which ind information as part service plans were would have to doub "disclosure" include required to be given	2022, at 12:30 p.m. license ctor (LALD)-A stated the r receiving the "disclosure of cluded dementia training of information received when signed. LALD-A stated, "I ble check" regarding if the ed the policies and procedures in to residents and the I designated representatives.					
	No further information	ion was provided.					
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one					
02140 SS=F	144G.83 Subd. 3 S	upervising staff training	02140				
	must have experier of individuals with of (1) two years of wo Alzheimer's disease health care, geronte and(2) completion of requirements in this	or overseeing staff training nee and knowledge in the care lementia, including: rk experience related to e or other dementias, or in ology, or another related field; of training equivalent to the s section and successfully npetency or knowledge test missioner.					
	This MN Requiremous	ent is not met as evidenced					

	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
02140	Continued From pa	ge 157	02140			
	licensee failed to de oversee staff trainir with dementia. This residents, staff, and This practice result violation that did no safety but had the p resident's health or widespread scope ( or represent a syste	and record review, the esignate a qualified person to ing in the care of individuals a had the potential to affect all d visitors. ed in a level two violation (a th harm a resident's health or potential to have harmed a safety), and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
		e conference on December 27,				
	director (LALD)-A s	licensed assisted living tated she oversaw training ndividuals with dementia.				
	stated, "I don't think training" referring to passing a skills con required by the con	2022, at 9:20 a.m. LALD-A (I have a separate test for completion of successfully npetency or knowledge test missioner as required. only had the "basic training dementia.				
	No further information	ion was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
02170 SS=D	144G.84 SERVICE DEMENTIA	S FOR RESIDENTS WITH	02170			
	(b) Each resident m	nust be evaluated for activities				
nesota Do	epartment of Health		6899 BE	3XB11	If continuation	-h

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETI DATE
02170	Continued From pa	ge 158	02170			
	addition, the evaluat following: (1) past and current (2) current abilities (3) emotional and s (4) physical abilities (5) adaptations nec- participate; and (6) identification of a interventions. (c) An individualized developed for each activity evaluation. resident's activity pt (d) A selection of da non-structured activi included on the resi- plan as appropriate on resident evaluati limited to: (1) occupation or ch (2) scheduled and p entertainment or ou (3) spontaneous activities (4) one-to-one activities (4) one-to-one activities resident's ability to a (5) spiritual, creative (6) sensory stimulai (7) physical activities resident's ability to a (8) outdoor activities This MN Requirement by: Based on observation review, the licensee	and skills; ocial needs and patterns; and limitations; essary for the resident to activities for behavioral d activity plan must be resident based on their The plan must reflect the references and needs. aily structured and vities must be provided and ident's activity service or care . Daily activity options based ion may include but are not hore related tasks; blanned events such as ttings; tivities for enjoyment or those a behavior; vities that encourage positive en residents and staff such as eminiscing, or playing music; e, and intellectual activities; tion activities; es that enhance or maintain a ambulate or move; and				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/	30/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
02170	Continued From pa	age 159	02170			
	was developed for	one of three residents (R3).				
	violation that did no safety but had the p resident's health or cause serious injur was issued at an is limited number of r a limited number of	ted in a level two violation (a ot harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and colated scope (when one or a esidents are affected or one or f staff are involved or the red only occasionally).				
	The findings includ	e:				
		luded early onset Alzheimer's sive mental deterioration which under age 65).				
		Addendum dated August 4, ivities escort daily and as				
	August 4, 2022, inc needed to support Frequently needs r disorientation to pe conditions that affe behaviors within the disorder, G. Demen needed to support that impact residen	or change of condition dated cluded "indicate any assistance orientation behaviors" was "C. edirection: moderate rrson, place, or time"; "indicate ct the resident's responsive e last year" was "B. Anxiety ntia"; "indicate any assistance identified conditions/diagnoses t's responsive behaviors " was care plan of need for behavior				
		Sheet dated December 2022, sident to activities of interest".				
		2022, at 7:58 a.m. R3 was a Broda chair (a positioning				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		33458	B. WING		12/	12/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
02170	Continued From pa	age 160	02170				
	television. At 8:14 a (ULP)-D was obser to R3 and gave R3 stated R3 liked mus coloring, would atte	iving room area watching a.m., unlicensed personnel rved to administer medications a baby doll to hold. ULP-D sic and liked to sing along, end music events in main lobby etimes staff would read a book					
	been evaluated for licensing rules of th following: - past and current i - current abilities ar - emotional and so - physical abilities a - adaptations neces participate; and	nd skills; cial needs and patterns;					
	activity plan develo evaluation, which re preferences and ne daily structured and being provided and	cord lacked an individualized ped based on an activity eflected the R3's activity eeds, including a selection of d non-structured activities l included on the resident's are plan as appropriate.					
	assisted living direc currently working o process" regarding	2022, at 12:30 p.m. licensed ctor (LALD)-A stated, "We are n with consultant, it is still in R3 lacked an evaluation for dividualized activity plan.					
	Programs, Activitie dated August 1, 20	5 ALDC Life Enrichment s and Outdoor Space policy 21, indicated as an assisted a care licensed facility the					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		33458	B. WING		12/	30/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
LADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
02170	Continued From pa	age 161	02170			
	Alzheimer's diseas "Activities and life of implemented in the licensee] offers a d incorporates both of focusing on self ca activities and produ An individual activities each resident base The plan must refle preferences and no and non-structured	tion was provided. R CORRECTION:				
02180 SS=D	DEMENTIA (e) Behavioral sym the resident and ot facility with dement included on the set must initiate and co	ES FOR RESIDENTS WITH ptoms that negatively impact hers in the assisted living tia care must be evaluated and rvice or care plan. The staff pordinate outside consultation	02180			
	significant relations basis but not less t (g) Access to secu walkways that allow	e offered to family and other ships on a regularly scheduled				
	This MN Requirem	ent is not met as evidenced				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		33458	B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
02180	by: Based on observat review, the licensee symptoms were ide the care plan for or This practice result violation that did no safety but had the p resident's health or cause serious injur was issued at an is limited number of re a limited number of situation has occur The findings includ R3's diagnoses inc dementia (progress occurs in someone R3's Service Plan A 2022, included the or intervention daily R3's assessment for August 4, 2022, inc needed to support Frequently needs re disorientation to pe conditions that affe behaviors within the disorder, G. Demer needed to support that impact residen	ion, interview, and record e failed to ensure behavioral entified and were addressed or ne of three residents (R3). ted in a level two violation (a ot harm a resident's health or potential to have harmed a resafety, but was not likely to y, impairment, or death), and colated scope (when one or a esidents are affected or one or f staff are involved or the red only occasionally). e: luded early onset Alzheimer's sive mental deterioration which e under age 65). Addendum dated August 4, service of behavior monitoring		DEFICIENC		

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		33458	B. WING		12/	12/30/2022	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
CLADDA	GH SENIOR LIVING		CKOW AVENU NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
02180	observed to admini crushed a total of n the medications in a administering the n medications observ B12 (used to treat of (mcg) two tablets; v units (IU) (used for milligrams (mg) (used disease), buspirone aripiprazole 5 mg of depression), buprof depression), buprof depression), buprof (used for back pain (used for back pain (used to treat diabe R3's Medication Re included buspirone daily, aripiprazole 5 daily and bupropior times a day for dep R3's Care Tracking identified "behavior has moments of for remember that she need to assist in re all times wen she is	ister medications to R3. ULP-D ine medications and placed applesauce prior to nedications to R3. The yed to be crushed were vitamin deficiency) 1,000 micrograms vitamin D3 5,000 international supplement), memantine 5 sed to treat Alzheimer's e 10 mg (used for anxiety), one half tablet (used for pion 100 mg (used for morphone 2 mg one half tablet h), and metformin 500 mg etes). ecord for December 2022, 10 mg take one tablet twice in g take one tablet twice in 100 mg take one tablet twice in 100 mg take one tablet three pression.					
	or believe that she hasn't. She has at t	/ fabricate information at times has done something when she times become more confused d won't understand why she is ure and redirect.					
	specific behaviors/s non-pharmalogical behavioral symptor specific non-pharm	Care Tracking Sheet lacked symptoms for depression and interventions to implement for ns of depression; lacked alogical interventions to suring and redirecting for wher					

Minnesota Department of Health           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	33458		B. WING		12/30/2022	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
CLADDA	AGH SENIOR LIVING		CKOW AVENU NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
02180	Continued From page 164		02180			
	that she has done s when becomes mo that negatively impa- lacked monitoring of for depression and aripiprazole, buprop medications. On December 29, 2 assisted living direc nurse (RN)-B state record lacked the a identify symptoms of The licensee's polic Symptoms, Interve Approaches dated licensee supports p based evaluation of design of supports including nonpharm practices in the follow would identify behan negatively impact of assisted living facilit potential intervention	2022, at 12:30 p.m. licensed ctor (LALD)-A and registered d, "okay" regarding R3's above. RN-B stated, "We don't or monitor". cy 3.02 ALDC Behavioral ntions and Nonpharmalogical August 1, 2021, indicated the berson-centered and evidence f behavioral symptoms and for intervention plans; nalogical interventions and owing ways: the licensee evioral symptoms that other residents and other in the ity and evaluate to determine ons to minimize such tions should be identified on rvice plan. ion was provided. R CORRECTION:	3			



Full

12/27/22

10:04:43

7920221271

Food and Beverage Establishment
Inspection Report

Page 1

#### Location:

Type: Date:

Time:

Report:

Claddagh Senior Living Llc 508 Kruckow Avenue North Caledonia, MN55921 Houston County, 28 Establishment Info: ID #: 0038236 Risk: Announced Inspection: No

License Categories:

#### - Operator:

Phone #: 5077255200 ID #:

Expires on: / /

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

Page 2

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 ManagerJennifer Schellhas

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

Signed:

Establishment Representative

Signed:

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