DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 21, 2023

Licensee
The Legacy Of St Michael
4400 Lange Avenue Northeast
Saint Michael, MN 55376

RE: Project Number(s) SL29185015

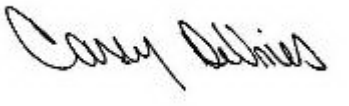
Dear Licensee:

On February 23, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 23, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-281-9796

JMD

Electronically Delivered

January 31, 2023

Licensee
The Legacy Of St Michael
4400 Lange Avenue Northeast
Saint Michael, MN 55376

RE: Project Number(s) SL29185015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 23, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1730 - 144g.71 Subd. 5 - Individualized Medication Management Plan - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $7,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

§ 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

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

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

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

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

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

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29185	A. BUILDING: _____ B. WING _____	12/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF ST MICHAEL	4400 LANGE AVENUE NE SAINT MICHAEL, MN 55376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29185015-0 On December 19, 2022, through December 23, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 88 residents, all of whom received services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on December 20, 2022, issued for SL29185015-0, tag identification 2310. On December 21, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all of the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Licensed assisted living director (LALD)-A had a license effective through October 31, 2023; however, LALD-A's license lacked the licensee listed as the Director of Record with BELTSS. During the entrance conference on December 19, 2022, at 10:20 a.m., LALD-A indicated she was not aware that she was not listed as the Director of Record for this facility and stated she would take care of this. No further information provided.	0 110		

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0 110	Continued From page 2 TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 430 SS=D	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for two of five residents (R3 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 430		

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0 430	Continued From page 3 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 and R4's records lacked evidence the resident received a copy of the licensee's UDALSA to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R3 R3's diagnoses included pancreatic cancer. R3's Service Addendum to the Assisted Living Contract dated April 3, 2022, indicated R3 received services including assistance with medication administration, bathing, dressing, and grooming. On December 22, 2022, at approximately 2:30 p.m., licensed assisted living director (LALD)-A stated R3 had not received the UDALSA, and she would look into it and send it to the family. R4 R4's diagnoses included diabetes with hyperglycemia (high blood glucose levels) and long-term use of insulin. R4's Service Addendum to the Assisted Living	0 430		

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0 430	Continued From page 4 Contract dated August 22, 2022, indicated R4 received services including assistance with toileting, transfers, medication administration, bathing, dressing, and blood glucose monitoring. R4's Resident Authorization, dated June 10, 2022, lacked a signature to indicate R4 had received the UDALSA. On December 22, 2022, at 2:48 p.m., LALD-A stated R4 and/or her representative had not signed the form to acknowledge they had received the UDALSA. The licensee's Client [resident] Record policy dated July 2021, lacked information on the UDALSA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those	0 500		

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0 500	Continued From page 5 services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required. This practice resulted in a level two violation (a	0 500		

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0 500	Continued From page 6 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 19, 2022, at approximately 10:20 a.m., the surveyors requested to review the licensee's current policies and procedures. On December 19, 2022, at 11:51 a.m., licensed assisted living director (LALD)-A provided a survey binder which contained several policies. On December 20, 2022, at 8:50 a.m., the surveyor requested LALD-A provide all policies the licensee attested to having when they applied for the license and all medication and treatment policies. The licensee failed to ensure the following policy was in place: - orientation to and implementation of the assisted living bill of rights. On December 22, 2022, at approximately 3:25 p.m., during a phone interview, LALD-A stated they would send the above policy. However, a policy related to orientation to and implementation of the assisted living bill of rights was not received. No further information was provided.	0 500		

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0 500	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for two of two employees (unlicensed personnel (ULP)-C and registered nurse (RN)-F), observed while providing cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 510		

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0 510	Continued From page 8 The findings include: On December 20, 2022, at 10:55 a.m., the surveyor observed ULP-C empty R3's urostomy bag. ULP-C donned clean gloves, wiped the port with an alcohol wipe, emptied the urine from the bag into a urinal, closed and wiped the port with an alcohol wipe, emptied the urine into the toilet, and rinsed the urinal. ULP-C removed the gloves and pushed R3 in his wheelchair to an activity. After leaving R3, ULP-C utilized hand sanitizer in the hallway. ULP-C then stated that was how she was trained to do hand hygiene. On December 20, 2022, at 11:25 a.m., the surveyor observed RN-F preparing to check R3's blood glucose prior to lunch. RN-F gathered the supplies out of the locked medication cupboard in R3's apartment, used hand sanitizer, donned gloves, cleansed R3's finger with an alcohol pad, used a lancet to poke the finger, and without wiping away the first drop of blood, RN-F placed a drop of blood onto the testing strip in the device. RN-F announced to R3 that his blood sugar result was 172. Without removing the gloves, RN-F scrolled with her fingers on the electronic device to verify the amount of insulin she would administer, reached into the medication cupboard, and touched items as she looked for the insulin pen. RN-F picked up the insulin pen, primed the insulin pen with two units of insulin, and dialed the insulin pen to 12 units. RN-F went to R3, cleansed the abdomen with the alcohol pad, and administered the insulin. RN-F removed the disposable needle from the insulin pen, placed it in the sharps container, and threw garbage into the trash. RN-F removed the soiled gloves and tossed them into the trash. Without performing hand hygiene, RN-F touched the screen on the electronic device, used keys to lock the medication cupboard, and then performed	0 510		

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0 510	Continued From page 9 hand hygiene with hand sanitizer. On December 20, 2022, at 11:33 a.m., the surveyor observed RN-F preparing to check R9's blood glucose prior to lunch. RN-F gathered the supplies out of the locked medication cupboard in R9's apartment, used hand sanitizer, donned gloves, cleansed R9's finger with an alcohol pad, used a lancet to poke the finger, and without wiping away the first drop of blood, RN-F placed a drop of blood onto the testing strip in the device. RN-F announced to R9 that his blood sugar result was 182, removed the testing strip from the device, and placed it on the kitchen counter. Without removing the gloves, RN-F scrolled with her fingers on the electronic device to verify the amount of insulin she would administer, reached into the medication cupboard, and touched items as she looked for the insulin pen. RN-F picked up the insulin pen, primed the insulin pen with two units of insulin, and dialed the insulin pen to 6 units. RN-F cleansed R9's abdomen with the alcohol pad, and administered the insulin. RN-F removed the disposable needle from the insulin pen and placed it in the sharps container, and threw garbage into the trash. Without removing the gloves, RN-F touched the screen on the electronic device, placed R9's testing equipment into the medication cupboard, used keys to lock the medication cupboard, removed the gloves, and then performed hand hygiene with hand sanitizer. When interviewed on December 20, 2022, at 11:43 a.m., RN-F stated the gloves should have been removed and hand hygiene completed after performing the blood glucose tests for R3 and R9, before touching other surfaces. On December 20, 2022, at 1:45 p.m., clinical	0 510		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 10 nurse supervisor (CNS)-B stated hand hygiene is to be performed after gloves are removed, and before touching anything. The licensee's Infection Prevention and Control Program policy, revised April 2020, lacked information on hand hygiene or glove use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report an allegation of abuse to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R7). 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	0 620		

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	29185	A. BUILDING: _____ B. WING _____	12/23/2022

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0 620	Continued From page 11 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 19, 2022, at 10:20 a.m., the surveyor made a request to the licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, regional corporate nurse (RCN)-J, and assistant executive director (AED)-H to review a list of all resident incident reports and all of the vulnerable adult reports the licensee had made to MAARC in the past six months, to which they indicated one report had been submitted. On December 19, 2022, at 1:19 p.m., one MAARC report was provided to the surveyors, regarding suspected financial exploitation. The MAARC report was reported timely. On December 21, 2022, at 1:25 p.m., a Resident Incident/Accident list was provided, which included the date and time of the incident, the resident's name, and the type of incident that occurred, including categories of witnessed and unwitnessed falls, bruises, skin tears, and "other." The surveyor made a request to review a selected list of the incidents, including R7's incident report, dated August 30, 2022, at 2:00 p.m., identified as "other." R7's Resident Incident Report, completed on September 3, 2022, by licensed practical nurse (LPN)-D, indicated on August 30, 2022, at 2:00 p.m., R7 reported she did not remember the date of the incident, but reported a male caregiver touched her inappropriately while he applied powder to her groin area. R7 reported the male	0 620		

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0 620	Continued From page 12 caregiver stated he wanted to give her a massage, have a child with her, and asked her to come and visit him after he was done caring for other residents. R7 reportedly told the male caregiver that she would like to date first before doing anything like this with him. R7 stated the male caregiver laid in her bed with her and stated this was upsetting because she wanted to go on a date before doing anything sexual with him. R7 reported she texted her guardians the next day, telling them she wanted to go home. The incident report indicated R7's guardian, physician's assistant, and CNS-B were notified, and two registered nurses (RN) performed a physical exam, with no signs or symptoms of trauma or injury. The incident report included a section titled Incident Investigation, which included R7 had impaired mental status, impaired safety judgement, cognitive impairment, and behaviors, and indicated R7's services were reviewed, medications reviewed, service plan was revised, service schedule reviewed, documentation in the resident's progress notes, and physical evaluation was completed. Also included, staffing patterns were reviewed, staff education provided, case worker and care team were updated. The male caregiver was interviewed, as well as other caregivers. Review of R7's Adverse Event Investigation, undated, indicated the incident was first reported by a physical therapist to CNS-B on August 30, 2022, at 11:00 a.m. R7 was examined by a RN with no observed signs of redness, irritation, or bruising, and no sign of injury. The male caregiver was interviewed and suspended pending investigation. R7's guardian was notified of the incident and the pending investigation. R7's provider was made aware of the situation, and other employees were interviewed regarding	0 620		

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0 620	Continued From page 13 interactions with R7 and the male caregiver. The summary and outcome of the investigative findings included, "Upon investigating incident and interview with [R7], it was discovered that this HHA [home health aide] [male caregiver] in question did not have access to R7's powders/creams and has not been assigned to administer medications to resident for over 3 months. ED [executive director] [LALD-A] interviewed [R7] regarding incident. Resident reports that HHA touched her inappropriately "the other day" while applying medication; however, HHA has not had access to this medication. Interview also provided conflicting information from resident." Also included, interviews with other employees determined that R7 had been sexually inappropriate at times with them, and had made sexual requests and comments. The summary included, "After resident exam, interview and employee interviews it was determined that HHA did not touch [R7] inappropriately." Review of R7's record indicated R7 was admitted to the facility on March 9, 2022, and had diagnoses including mild cognitive impairment, Wernicke-Korsakoff Dementia (a memory disorder resulting from vitamin B1 deficiency), adjustment disorder with mixed anxiety and depressed mood, alcohol abuse, and traumatic brain injury. R7's Service Addendum to the Assisted Living Contract, dated September 9, 2022, indicated R7 received services including assistance with transfers, bathing, in-room dining, dressing, grooming, behavior observation, toileting, and medication administration. R7's Vulnerability Evaluation, dated March 7,	0 620		

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0 620	Continued From page 14 2022, indicated R7 was not able to report abuse or neglect, and interventions included monitoring resident and reporting concerns to nurse immediately. Also noted, R7 was considered vulnerable for abuse by others and had a history of sexual inappropriateness, and interventions included monitoring and redirecting resident from inappropriate conversations and physical inappropriateness with other residents or staff, and to report to nurse immediately. R7's progress notes lacked mention of the reported incident. On December 22, 2022, at 3:20 p.m., LALD-A indicated an investigation was conducted when R7 reported being touched inappropriately and the male caregiver was interviewed and was suspended, pending the investigation. LALD-A stated R7 was interviewed, as well as other residents and employees. LALD-A stated a MAARC report was not submitted and indicated she had talked to her supervisor and didn't feel that the incident was reportable or that filing a MAARC report was necessary. The licensee's Vulnerable Adult/Maltreatment-Communication, Prevention, and Reporting (626.557) policy, revised October 2022, indicated all residents are considered vulnerable and "Abuse must be reported," including any act against a vulnerable adult which constitutes a violation of Minnesota's criminal statutes, including assault and battery or criminal sexual conduct. Also included, "All staff of Facility shall immediately make a report to the Minnesota Adult Abuse Reporting Center (MAARC)," via the website or telephone. Further, "To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the	0 620		

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0 620	Continued From page 15 nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for five of five residents (R2, R3, R4, R5, and R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 630		

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0 630	Continued From page 16 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2, R3, R4, R5, and R6's records lacked an individual abuse prevention plan to include an assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults. R2 R2's diagnoses included Alzheimer's disease. R2's unsigned Service Addendum to the Assisted Living Contract dated effective December 7, 2022, indicated the resident received services including assistance with medication administration, toileting, and bathing. R2's NEW Nursing Assessment dated November 11, 2022, noted areas of vulnerabilities with statements of specific measures to be taken to minimize the risk of abuse, and the person's risk of abusing other vulnerable adults. However, the assessment lacked an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults. R3 R3's diagnoses included pancreatic cancer. R3's Service Addendum to the Assisted Living Contract dated April 3, 2022, indicated the resident received services including assistance	0 630		

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0 630	Continued From page 17 with medication administration, bathing, dressing, and grooming. R3's NEW Nursing Assessment dated October 12, 2022, noted areas of vulnerabilities with statements of specific measures to be taken to minimize the risk of abuse, and the person's risk of abusing other vulnerable adults. However, the assessment lacked an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults. R4 R4's diagnoses included diabetes with hyperglycemia (high blood glucose levels) and long-term use of insulin. R4's Service Addendum to the Assisted Living Contract dated August 22, 2022, indicated R4 received services including assistance with toileting, transfers, medication administration, bathing, dressing, and blood glucose monitoring. R4's NEW Nursing Assessment, dated November 11, 2022, noted areas of vulnerabilities with statements of specific measures to be taken to minimize the risk of abuse, and the person's risk of abusing other vulnerable adults; however, the assessment lacked an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults. R5 R5's diagnoses included diabetes and Parkinson's Disease. R5's Service Addendum to the Assisted Living Contract, dated November 1, 2022, indicated R5 received services including assistance with	0 630		

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0 630	Continued From page 18 toileting, transfers, bathing, monthly vital signs, and bedmaking. R5's NEW Nursing Assessment, dated October 18, 2022, noted areas of vulnerabilities with statements of specific measures to be taken to minimize the risk of abuse, and the person's risk of abusing other vulnerable adults; however, the assessment lacked an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults. R6 R6's diagnoses included chronic kidney disease, depression, anxiety, and peripheral vascular disease. R6's Service Addendum to the Assisted Living Contract, dated August 16, 2022, indicated R6 received services including assistance with toileting, catheter care, transfers, bathing, dressing, grooming, hearing aid, monthly vital signs, and escort. R6's NEW Nursing Assessment, dated October 31, 2022, noted areas of vulnerabilities with statements of specific measures to be taken to minimize the risk of abuse, and the person's risk of abusing other vulnerable adults; however, the assessment lacked an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults. On December 22, 2022, at approximately 2:30 p.m., clinical nurse supervisor (CNS)-B said the assessment does not specifically address the susceptibility to abuse by another individual, and stated the same format was utilized for all	0 630		

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0 630	Continued From page 19 residents. The licensee's Vulnerable Adult / Maltreatment - Communication, Prevention, and Reporting policy revision date October 2022 noted the licensee would evaluate the individual's susceptibility of abuse and also evaluate the individual's risk of abusing other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all of the	0 640		

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0 640	Continued From page 20 licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility; and - post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. During the facility tour on December 19, 2022, at 11:20 a.m., the surveyors observed the entry area, common areas, kitchen, and dining areas within the facility with clinical nurse supervisor (CNS)-B and noted there was no posting of the 911 emergency number or information and reporting number for MAARC, as required. On December 19, 2022, at 12:55 p.m., licensed assisted living director (LALD)-A said the 911 emergency number and the MAARC information was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		

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

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0 650	Continued From page 22 registered nurse (RN)-F, unlicensed personnel (ULP)-C, and licensed practical nurse (LPN)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-B CNS-B was hired on February 6, 2022, to provide assisted living services. CNS-B's employee record lacked evidence of: - a review of the types of services the employee would provide and the provider's scope of license. RN-F RN-F started employment on September 25, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-F's employee record lacked evidence of: - a review of the types of services the employee would provide and the provider's scope of license. ULP-C ULP-C was hired on August 23, 2022, to provide assisted living services. ULP-C's employee record lacked evidence of: - a review of the types of services the employee would provide and the provider's scope of license.	0 650		

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0 650	Continued From page 23 LPN-G LPN-G started employment on February 27, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. LPN-G's employee record lacked evidence of: - a review of the types of services the employee would provide and the provider's scope of license. On December 22, 2022, at approximately 3:52 p.m., assistant executive director (AED)-H stated the content is reviewed on orientation, however it is not documented in the employee file. The licensee's Orientation policy dated November 2018, lacked information on the review of the types of services the employee would provide and the provider's scope of license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680		

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0 680	Continued From page 24 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all of the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 19, 2022, at 12:45 p.m., the surveyor observed the Assisted Living Disaster and Emergency Plan, dated August 24, 2021, in a	0 680		

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	29185	A. BUILDING: _____ B. WING _____	12/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 680	Continued From page 25 white binder on the bottom shelf of a small table in the common area, near the reception desk. The licensee's plan lacked the following required content: - procedure for tracking staff and residents; and - EP testing/annual testing requirements. On December 22, 2022, at 3:34 p.m., licensed assisted living director (LALD)-A and regional operations manager (ROM)-K stated the information provided regarding the emergency preparedness plan was everything the licensee had available and indicated there was no policy/procedure developed to track the location of on-duty staff and sheltered residents, and if relocated, no procedure in place to document the specific name/location of the receiving facility or other location. In addition, LALD-A and ROM-K stated they conducted an active shooter drill to test their EP plan on November 9, 2022; however, had not conducted a second exercise to test the EP plan, or at least twice per year, as required. The licensee's Disaster and Emergency Plan overview, included in the emergency preparedness binder, dated August 24, 2021, lacked direction to develop a procedure to track on-duty staff and residents. The overview noted the training and testing program was based on the emergency plan, risk assessment, policies and procedures, and the communication plan and noted drills and/or exercises were conducted routinely to test the emergency plan to identify gaps and areas for improvement. The overview indicated "Exercises to test the emergency plan are completed annually," and the facility participated in either a full-scale community-based or a facility-based functional exercise every two years, and would analyze the	0 680		

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0 680	Continued From page 26 facility response to and maintain documentation of all drills, tabletop exercises, and emergency events in an After-Action Review, and revise the facility's emergency plan, as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to	0 730		

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0 730	Continued From page 27 the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R1). 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:	0 730		

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0 730	Continued From page 28 R1's record lacked a discharge summary to include: - diagnoses; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R1 was admitted to the licensee on June 3, 2016, with diagnoses including chronic kidney disease, coronary atherosclerosis (a condition affecting the arteries that supply oxygen-rich blood to the heart), type 2 diabetes, essential hypertension (high blood pressure), anemia (low healthy red blood cells), and history of breast cancer and bladder cancer. R1 was discharged on October 3, 2022. R1's progress notes lacked information related to R1's discharge. On December 22, 2022, at 3:10 p.m., clinical nurse supervisor (CNS)-B stated R1's discharge summary did not include all the required components. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 29 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to	0 810		

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0 810	Continued From page 30 the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: During interview on December 19, 2022, at 2:30 p.m., the regional maintenance engineer (RME)-I stated they had not completed any trainings for staff and residents or evacuation drills. Review of the fire safety policy showed the following: 1. No record of required employee evacuation drills. 2. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 3. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 31 (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for five of five residents (R2, R3, R4, R5, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee lacked a written contract with the following required content: - the telephone number for the managing agent of	0 910		

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0 910	Continued From page 32 the facility; and - the telephone number for the authorized agent for the facility. R2's Assisted Living Contract, dated October 5, 2022, included the legal name and the license number of the facility, the name, telephone number, and physical mailing address of the facility and managing entity, and the name and physical mailing address of the managing agent and the authorized agent for the facility, identified as licensed assisted living director (LALD)-A; however, lacked the telephone number, as required. R3's Assisted Living Contract, dated April 2, 2022, included the legal name and the license number of the facility, the name, telephone number, and physical mailing address of the facility and managing entity, and the name and physical mailing address of the managing agent and the authorized agent for the facility, identified as LALD-A; however, lacked the telephone number, as required. R4's Assisted Living Contract, dated September 5, 2022, included the legal name and the license number of the facility, the name, telephone number, and physical mailing address of the facility and managing entity, and the name and physical mailing address of the managing agent and the authorized agent for the facility, identified as LALD-A; however, lacked the telephone number, as required. R5's Assisted Living Contract, dated September 27, 2022, included the legal name and the license number of the facility, the name, telephone number, and physical mailing address of the facility and managing entity, and the name and	0 910		

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0 910	Continued From page 33 physical mailing address of the managing agent and the authorized agent for the facility, identified as LALD-A; however, lacked the telephone number, as required. R6's Assisted Living Contract, dated August 9, 2021, included the legal name and the license number of the facility, the name, telephone number, and physical mailing address of the facility and managing entity; however, had a different name listed as the managing and authorized agent with the same physical mailing address, and lacked the telephone number, as required. On December 22, 2022, at 3:27 p.m., via telephone interview, licensed assisted living director (LALD)-A indicated she was the managing agent and the authorized agent for the facility, and that the contract, received by all residents, should include her name, telephone number, and physical mailing address. LALD-A stated she had a recent name change and her last name would need to be changed on the contract, and stated R6's contract included the name and address of the prior LALD for the facility, who no longer worked for the facility, and was also missing the telephone number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support	0 940		

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0 940	Continued From page 34 program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for five of five residents (R2, R3, R4, R5, R6).	0 940		

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0 940	Continued From page 35 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2, R3, R4, R5, and R6's records lacked a written contract to include: - a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required. R2's unsigned Service Addendum to the Assisted Living Contract dated effective December 7, 2022, indicated R2 received services including assistance with medication administration, toileting, and bathing. R2's Assisted Living Contract, dated October 5, 2022, lacked the content described above. R3's Service Addendum to the Assisted Living Contract dated April 3, 2022, indicated R3 received services including assistance with medication administration, bathing, dressing, and grooming. R3's Assisted Living Contract, dated April 2, 2022,	0 940		

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0 940	Continued From page 36 lacked the content described above. R4's Service Addendum to the Assisted Living Contract dated August 22, 2022, indicated R4 received services including assistance with toileting, transfers, medication administration, bathing, dressing, and blood glucose monitoring. R4's Assisted Living Contract, dated September 5, 2022, lacked the content described above. R5's Service Addendum to the Assisted Living Contract, dated November 1, 2022, indicated R5 received services including assistance with toileting, transfers, bathing, monthly vital signs, and bedmaking. R5's Assisted Living Contract, dated September 27, 2022, lacked the content described above. R6's Service Addendum to the Assisted Living Contract, dated August 16, 2022, indicated R6 received services including assistance with toileting, catheter care, transfers, bathing, dressing, grooming, hearing aid, monthly vital signs, and escort. R6's Assisted Living Contract, dated August 9, 2021, lacked the content described above. On December 22, 2022, at 3:27 p.m., via telephone interview, licensed assisted living director (LALD)-A indicated she wasn't aware that the contract was missing the above content and verified the contract was the same contract used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 940		

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0 940	Continued From page 37 (21) days	0 940		
0 970 SS=D	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract for two of five residents (R3 and R6) did not include language waiving facility liability for resident health, safety, or personal property. 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 R3 was admitted on January 21, 2021, with diagnoses including pancreatic cancer. R3's Assisted Living Contract dated April 2, 2022,	0 970		

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0 970	Continued From page 38 included a clause on page 16, section 2, Indemnification, "Resident will indemnify and hold harmless Provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Provider's property, or caused wholly or in part by an act of omission of Resident or Resident's guests or agents." Also included, on page 16, section 4, Liability, "provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third party providers. Provider may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises." R6 was admitted on August 1, 2011, with diagnoses including chronic kidney disease, depression, anxiety, and peripheral vascular disease. R6's Assisted Living Contract, dated August 9, 2021, included a clause on page 16, section 2, Indemnification, "Resident will indemnify and hold harmless Provider, its employees and agents	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29185	A. BUILDING: _____ B. WING _____	12/23/2022

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0 970	Continued From page 39 from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Provider's property, or caused wholly or in part by an act of omission of Resident or Resident's guests or agents." Also included, on page 16, section 4, Liability, "Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third party providers. Provider may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises." On December 22, 2022, at 3:27 p.m., via telephone interview, licensed assisted living director (LALD)-A stated the contract had been revised recently and the language had been changed and indicated she wasn't aware that R3 and R6 had not been given and signed the new contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 970		

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0 970	Continued From page 40 (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060		

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01060	Continued From page 41 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for two of two residents (R2 and R6) hospitalized. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 and R6's records lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the	01060		

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01060	Continued From page 42 resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. R2 R2's diagnoses included Alzheimer's disease. R2's unsigned Service Addendum to the Assisted Living Contract effective date of December 7, 2022, noted services including assistance with medication administration, toileting, and transfers. R2's Progress Notes noted the following: - May 28, 2022, R2 was found on the floor by staff after supper, and was sent to the emergency room via ambulance; - May 29, 2022, R2 was transferred to a different hospital; - June 1, 2022, R2 was transferred to a transitional care unit; and - June 23, 2022, resident returned to the facility. R6 R6's diagnoses included chronic kidney disease, depression, anxiety, and peripheral vascular disease. R6's Service Addendum to the Assisted Living Contract, dated August 16, 2022, indicated R6 received services including assistance with toileting, catheter care, transfers, bathing, dressing, grooming, hearing aid, monthly vital signs, and escort. R6's Progress Notes noted the following: - On April 10, 2022, at 9:33 a.m., R6's daughter called and requested to have a full assessment completed on R6 and requested R6 to have an order for morphine because R6 was in pain and was having difficulty breathing. R6 was noted to have audible wheezing and was offered her	01060		

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01060	Continued From page 43 nebulizer which she refused. Provider was updated; - On April 10, 2022, at 9:42 a.m., orders were received to give extra Lasix (decrease fluid retention) and increase Ativan (treat anxiety); - On April 10, 2022, at 10:48 p.m., R6's daughter called, requesting staff to check on R6, because the extra Lasix was not working, and she was still anxious. Licensed practical nurse (LPN)-L recommended that R6 be sent to the emergency room for evaluation. R6 was sent to the hospital and was admitted with diagnosis of heart failure; - On April 13, 2022, at 2:57 p.m., R6 returned to the facility. On December 22, 2022, at approximately 1:35 p.m., via telephone interview, clinical nurse supervisor (CNS)-B stated the required written notice had not been provided to any residents hospitalized and from her understanding, the notice was meant for nursing homes, not assisted living facilities. In addition, CNS-B stated it was not something the corporate office had instructed them to do. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not	01540		

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01540	Continued From page 44 provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed the required amount of dementia care training in the required time frame for one of four employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2022. ULP-C was hired on August 23, 2022, to provide assisted living services. ULP-C's employee record contained evidence of	01540		

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01540	Continued From page 45 4.0 hours training dated September 1, 2022, on dementia care topics within 80 hours of the start date. ULP-C reached 80 working hours on September 14, 2022. On December 22, 2022, at approximately 3:52 p.m., assistant executive director (AED)-H stated she would look to see how many hours had been completed. However, no further documentation was provided other than the above noted 4.0 hour certificate for dementia basics. The licensee's undated Minnesota Assisted Living (144G) (Company standards not matter with or without Memory Care) form provided noted direct care staff would receive 8 hours of training within 80 working hours after the first day of hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620		

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01620	Continued From page 46 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed resident reassessment and monitoring no more than 14 calendar days after initiation of services for two of five residents (R4, R5), and within 90 calendar days from the date of the last review for one of five residents (R2), as required. In addition, the licensee failed to ensure the RN completed a reassessment based on changes in the needs of the resident for one of five residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on December 19,	01620		

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01620	Continued From page 47 2022, at 10:37 a.m., clinical nurse supervisor (CNS)-B stated an initial comprehensive assessment was completed prior to the resident moving into the facility, then within five days of admission, then within 90 days, and then annually. 14 DAY ASSESSMENTS R4 R4 was admitted for services on June 10, 2022, with diagnoses including diabetes with hyperglycemia (high blood glucose levels) and long-term use of insulin. R4's Service Addendum to the Assisted Living Contract dated August 22, 2022, indicated R4 received services including assistance with toileting, transfers, medication administration, bathing, dressing, and blood glucose monitoring. R4's NEW Nursing Assessment, identified as the admission (initial) assessment, indicated the assessment was completed on June 9, 2022. R4's next reassessment was dated August 18, 2022, 69 days after the initiation of services, and identified as a change of condition assessment. R4's record lacked evidence a nursing reassessment and monitoring was completed no more than 14 days after initiation of services, as required. On December 22, 2022, at 2:43 p.m., via telephone interview, CNS-B stated a 14-day reassessment was not completed for R4. R5 R5 was admitted for services on April 28, 2022, with diagnoses including diabetes and Parkinson's Disease.	01620		

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01620	Continued From page 48 R5's Service Addendum to the Assisted Living Contract, dated November 1, 2022, indicated R5 received services including assistance with toileting, transfers, bathing, monthly vital signs, and bedmaking. R5's Nursing Admission Assessment was completed on April 22, 2022. R5's Comprehensive Assessment, identified as "14 Day Review," was dated May 19, 2022, 21 days after the initiation of services. R5's record lacked evidence a nursing reassessment and monitoring was completed no more than 14 days after initiation of services, as required. On December 22, 2022, at 2:54 p.m., via telephone interview, CNS-B indicated R5's 14-day reassessment was not completed timely. 90 DAY ASSESSMENT AND CHANGE IN CONDITION ASSESSMENT R2 R2's diagnoses included Alzheimer's disease. R2's unsigned Service Addendum to the Assisted Living Contract dated effective December 7, 2022, indicated R2received services including assistance with medication administration, toileting, and bathing. R2's record contained a Comprehensive Assessment dated February 10, 2022, and May 19, 2022 (98 days after the last assessment). In addition, R2 was hospitalized and transferred to a transitional care unit being absent from the facility from May 28, 2022, through June 23, 2022. R2's record lacked an assessment after return to the facility until August 16, 2022, (54 days later).	01620		

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01620	Continued From page 49 On December 22, 2022, at approximately 1:35 p.m., CNS-B stated R2's May assessment was late, and said a reassessment had not been completed upon return from the hospital, as is their policy to do. The licensee's Comprehensive Assessment Schedule guidelines, revision date August 2022, noted ongoing client [resident] monitoring and reassessment would be completed at least every 90 days and as indicated with changes in the client [resident] condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	01640		

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01640	Continued From page 50 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current written service plan was revised to reflect the current services provided for one of five residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R4 was admitted for services on June 10, 2022, with diagnoses including diabetes with hyperglycemia (high blood glucose levels) and long-term use of insulin. R4's Service Addendum to the Assisted Living Contract dated August 22, 2022, indicated R4 received services including assistance with toileting, transfers, medication administration, bathing, dressing, and blood glucose monitoring three times per day, at 8:00 a.m., 12:00 p.m., and at 4:00 p.m. R4's Medication Administration Records (MAR), dated November 2022, and December 2022,	01640		

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01640	Continued From page 51 included, "UNISTIK 3 MIS COMFORT [brand of lancets] USE AS DIRECTED TO TEST BLOOD SUGAR THREE TIMES DAILY." Documentation included blood sugar results at 8:00 a.m. and at 4:30 p.m.; however, the MAR lacked documentation of the results of the 12:00 p.m. blood sugar. R4's Physician Order Sheet, signed October 4, 2022, included, "Decrease BG [blood glucose] check to once daily in the evening." On December 23, 2022, at 11:10 a.m., clinical nurse supervisor (CNS)-B indicated the order for R4's blood glucose testing had changed to decrease R4's blood sugar checks to once daily in the evening, and stated she could not explain why the MAR and the service plan had not been revised to accurately reflect the current orders and the services being provided. CNS-B stated both should have been changed. The licensee's Service Plan guideline, undated, indicated the assisted living provider must implement and provide all services required by the current service plan and the service plan must be revised, if needed, based on the results of required resident monitoring and/or reassessments. Also included, the service plan and any revision must include a signature or other authentication by the assisted living provider and by the resident or the resident's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 52	01650		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included the required content for three of five residents (R2, R3, and R6).	01650		

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	29185	A. BUILDING: _____ B. WING _____	12/23/2022

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01650	Continued From page 53 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2, R3, and R6's records lacked a service plan to include the required content. R2 R2's diagnoses included Alzheimer's disease. R2's unsigned Service Addendum to the Assisted Living Contract dated effective December 7, 2022, indicated R2 received services including assistance with medication administration, toileting, and bathing. However, it lacked the following: - identification of and information as to who has the authority to sign for the resident in an emergency. On December 22, 2022, at approximately 1:35 p.m., clinical nurse supervisor (CNS)-B stated the service plan lacked the required content, and added there was a glitch when printing the service plan for R3 which left out the information on who has the authority to sign in an emergency. R3 R3's diagnoses included pancreatic cancer. R3's Service Addendum to the Assisted Living	01650		

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01650	Continued From page 54 Contract dated April 3, 2022, indicated R3 received services including assistance with medication administration, bathing, dressing, and grooming. However, it lacked the following: - methods of monitoring staff providing services. On December 22, 2022, at approximately 2:30 p.m., CNS-B stated the service plan lacked the required content and stated they had done a lot of updating. R6 R6 was admitted for services on August 1, 2011, with diagnoses including chronic kidney disease, depression, anxiety, and peripheral vascular disease. R6's Service Addendum to the Assisted Living Contract, dated August 16, 2022, indicated R6 received services including assistance with toileting, catheter care, transfers, bathing, dressing, grooming, hearing aid, monthly vital signs, and escort. The service plan lacked the following: - identification of and information as to who has the authority to sign for the resident in an emergency. On December 22, 2022, at 2:03 p.m., CNS-B stated the service plans lacked the required content and stated the same service plan was utilized for all residents. The licensee's Service Plan policy, revision date December 2022, noted required elements of the service plan including the schedule and methods of monitoring reviews or assessments of the client [resident], the frequency of sessions of supervision of staff and type of personnel who would supervise them, and the names and	01650		

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01650	Continued From page 55 contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and information as to who has the sign for the client in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal	01690		

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01690	Continued From page 56 and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures that were developed under the supervision and direction of a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 19, 2022, at approximately 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the licensee's residents. At this time, the surveyors requested to review the licensee's current medication policies and procedures. On December 19, 2022, at 11:51 a.m., licensed assisted living director (LALD)-A provided a	01690		

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01690	Continued From page 57 survey binder, which contained several policies. On December 20, 2022, at 8:50 a.m., the surveyor requested LALD-A provide all policies the licensee attested to having when they applied for the license including all medication and treatment policies. The licensee lacked the following policies: - verifying that prescription drugs are administered as prescribed; - monitoring and evaluating medication use; - communicating with the prescriber, pharmacist, and resident and legal and designated representatives; and - educating residents and legal and designated representatives about medications. On December 22, 2022, at approximately 3:25 p.m., during a phone interview, LALD-A stated they would send them. However, policies related to the above were not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01690		
01730 SS=G	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	01730		

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01730	Continued From page 58 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for one of five residents (R8).	01730		

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01730	Continued From page 59 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 19, 2022, at 10:20 a.m., licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, regional corporate nurse (RCN)-J, and assistant executive director (AED)-H stated the licensee provided medication management services to residents at the facility. R8's diagnoses included chronic atrial fibrillation (irregular, often fast heartbeat), long term use of anticoagulants, complete heart block (electrical signal that controls your heartbeat is partially or completely blocked (electrical signal that controls heartbeat is partially or completely blocked), history of deep vein thrombosis (blood clot), and heart failure. R8's Service Addendum to the Assisted Living Contract, dated August 16, 2022, indicated R8 received services which included monthly vital signs, bathing, compression stockings, escort cueing/reminders, daily medical monitoring, and assistance with medication administration. R8's NEW Nursing Assessment, dated July 15, 2022, identified as the admission assessment, included a Medication and Treatment Evaluation	01730		

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01730	Continued From page 60 and Management Plan, which indicated R8 received medication management with community unlicensed staff responsible to administer medications and the nurse responsible for reordering medication from the pharmacy. The plan indicated all medications and treatments had been reviewed, face to face, with R8 and/or the responsible party. The plan indicated the RN should be notified with problems or concerns with medication management and indicated there were no changes to the medication management plan. The plan summary included, "Medications ordered by MD [medical doctor], orders sent to Total Care Pharmacy, orders processed and delivered to The Legacy of St. Michael, where a nurse reviews them and checks them in then locks them in medication cabinet and a trained home health aide administers them." The medication management plan failed to provide direction describing the medication management service of anticoagulation therapy monitoring. R8's NEW Nursing Assessment, dated October 13, 2022, identified as the 90-day assessment, included a Medication and Treatment Evaluation and Management Plan, which indicated all medications and treatments had been reviewed, face to face, with the resident and/or responsible party and medication administration was provided by community unlicensed staff. The plan noted the nurse was responsible for reordering medications from the pharmacy and medications were locked in R8's apartment. Also included, there was no change in the medication plan and specific instructions noted, "Refer to MAR for client [resident] receiving assist." The medication management plan failed to provide direction describing the medication management service of anticoagulation therapy monitoring.	01730		

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01730	Continued From page 61 R8's prescriber orders, dated August 2, 2022, included R8's International Normalized Ratio (INR) results were 2.1 (normal 0.8-1.1), with orders to continue Coumadin (same as warfarin) (blood thinner) 2.5 milligrams (mg) by mouth Tuesday, Thursday, Saturdays, and Coumadin 1.25 mg by mouth on Monday, Wednesday, Friday, and Sunday, and an INR on August 23, 2022, and noted "(Lifespark [facility's onsite provider] will do)." R8's Medication Administration Record (MAR), dated August 2022, indicated, effective July 19, 2022, through August 2, 2022, warfarin 2.5 mg tablet by mouth on Tuesday, Thursday, and Saturday and warfarin 2.5 mg take 1/2 tablet (1.25 mg) by mouth on Monday, Wednesday, and Friday, and indicated INR August 2, 2022. The MAR also included, effective August 2, 2022, with an end date of August 23, 2022, warfarin 2.5 mg one tablet by mouth on Tuesday, Thursday, and Saturday, and warfarin 2.5 mg take 1/2 tablet (1.25 mg) by mouth on Sunday, Monday, Wednesday, and Friday, with INR on August 23, 2022. Initials were documented in each box, August 1, 2022, through August 23, 2022, indicating the warfarin was administered. There was no further documentation of warfarin administration until September 18, 2022, as noted on MAR dated September 2022. R8's Medication Incident Report, dated September 17, 2022, at 6:00 p.m., identified the type of incident as "Missed Medication," and indicated R8's daughter reported R8 had an INR on August 18, 2022. The report indicated no orders were received by the facility, and R8 did not receive warfarin from August 23, 2022, through September 18, 2022. R8's daughter reported to the licensed practical nurse (LPN) that	01730		

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01730	Continued From page 62 she "might not have brought to [sic] orders to the facility," and stated "do I have to?" The Incident Investigation indicated the LPN contacted the anticoagulant clinic and received new orders on September 19, 2022, and developed plan going forward. Order processing was updated with the pharmacy and pharmacy planned to profile any warfarin orders at 4:00 p.m. Services were updated to reflect changes along with an email to all nurses with this information. R8's progress notes, dated August 18, 2022, at 4:41 p.m., indicated LPN-L received an after-visit summary from R8's daughter with instructions to continue Lasix (treat fluid retention) daily, limit sodium to less than 2000 milligrams daily, wear compression stockings on in the morning and off at bedtime, and to continue with daily weight. Also included, R8's daughter reported an INR was completed. R8's record lacked documentation of INR results or follow up with warfarin orders. R8's progress notes, dated September 17, 2022, at 5:09 p.m., indicated R8 had an unwitnessed fall in her apartment and, due to findings of reddened areas on her head, family agreed to transport R8 to the hospital to be evaluated. At 9:34 p.m., staff received an update from R8's daughter who asked if R8 would be receiving her warfarin when she returned to the facility. LPN-L told R8's daughter that R8 was not currently taking warfarin. R8's daughter ensured LPN-L that R8 was still taking warfarin. LPN-L reviewed R8's nursing notes and noted R8 had a medical appointment on August 18, 2022. R8's daughter stated blood was drawn at the appointment. R8's daughter stated she may not have brought the orders to the nursing staff. LPN-L went to R8's apartment to look for the after-visit summary. CNS-B was notified via email of the missed	01730		

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01730	Continued From page 63	01730		

medication and R8's daughter stated she would call CNS-B. On September 17, 2022, at 11:41 p.m., LPN-L called the hospital for another update and hospital nurse reported R8 had a urinary tract infection and may be discharged. On September 18, 2022, at 7:32 a.m., R8's daughter answered the door when staff went to check on R8 in her apartment, and reported R8 returned to the facility around 3:00 a.m., with new orders to contact primary care provider on Monday (September 19, 2022) to request prescription for warfarin, take antibiotic as ordered, take pain reliever as needed and use ice packs, and to follow up with PCP in 5-7 days. On September 18, 2022, at 10:41 a.m., triage registered nurse (RN) was contacted by the LPN and on-call physician was contacted. Orders were received to give warfarin 2.5 milligrams that evening and to call in the morning for further instructions. On September 18, 2022, at 12:15 p.m., triage RN documented she was contacted by nursing staff for guidance with above situation. Triage RN noted R8's INR was 1.1 (INR of 1.1 or below is considered normal) and indicated she encouraged nursing staff to reach out to primary clinic after hours on call, for guidance on Coumadin (same as warfarin). On September 19, 2022, at 2:04 p.m., RN-E documented the anticoagulation clinic would be faxing dosing of warfarin to the pharmacy and the facility today. On September 19, 2022, at 3:15 p.m., RN-E indicated she had discussed with CNS-B and R8's son about R8's missed warfarin, and noted R8's daughter had brought R8 to an anticoagulation clinic for her INR draw on August 18, 2022; however, the facility was not aware of which anticoagulation clinic R8 was brought to and did not receive new orders for warfarin dosing. R8's son was upset that R8 had missed her warfarin and that the facility had not contacted

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01730	Continued From page 64 the anticoagulation clinic for orders. It was discussed that outside providers were required to fax orders to the facility or written orders must be brought to the facility to be able to order the medication from the pharmacy. Anticoagulation clinic was contacted by RN-E and requested orders be sent to pharmacy, as well as the facility. On September 19, 2022, at 8:13 p.m., LPN-L documented she contacted a nurse from the anticoagulation clinic and received orders for warfarin, and discussed the plan moving forward to prevent further issues. The nurse from the anticoagulation clinic explained R8's family had canceled her services with them, and was the reason the orders were not communicated to the facility. On December 23, 2022, at 10:14 a.m., via telephone interview, CNS-B stated the facility's onsite provider was managing R8's warfarin and INR results; however, the family made the decision to utilize an outside anticoagulation clinic and didn't inform the facility of the change, therefore, the INR results did not get communicated to the facility and there were no warfarin orders. CNS-B indicated she didn't know how this was missed and stated this should have been followed up on and the medication plan should have been updated when changes were made. CNS-B stated reeducation was provided to nursing staff. The licensee's Medications and Treatments guideline, undated, noted a current individualized Medication and Treatment Management Plan would be developed and maintained based on the resident assessment, would be conducted in person by a registered nurse, face to face with the resident, prior to receiving services, annually and with a change in condition.	01730		

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01730	Continued From page 65 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of 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 interview and record review the facility failed to ensure follow-up procedures were provided to meet the resident's needs when ordered laboratory services and subsequent medication orders were not completed for one of one resident (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01760		

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01760	Continued From page 66 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 19, 2022, at 10:20 a.m., licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, regional corporate nurse (RCN)-J, and assistant executive director (AED)-H stated the licensee provided medication management services to residents at the facility. R8's diagnoses included chronic atrial fibrillation (irregular, often fast heartbeat), long term use of anticoagulants, complete heart block (electrical signal that controls your heartbeat is partially or completely blocked (electrical signal that controls heartbeat is partially or completely blocked), history of deep vein thrombosis (blood clot), and heart failure. R8's Service Addendum to the Assisted Living Contract, dated August 16, 2022, indicated R8 received services which included monthly vital signs, bathing, compression stockings, escort cueing/reminders, daily medical monitoring, and assistance with medication administration. R8's NEW Nursing Assessment, dated July 15, 2022, identified as the admission assessment, included a Medication and Treatment Evaluation and Management Plan, which indicated R8 received medication management with community unlicensed staff responsible to administer medications and the nurse responsible for reordering medication from the pharmacy. The plan indicated all medications and treatments had been reviewed, face to face, with R8 and/or the	01760		

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responsible party. The plan indicated the RN should be notified with problems or concerns with medication management and indicated there were no changes to the medication management plan. The plan summary included, "Medications ordered by MD [medical doctor], orders sent to Total Care Pharmacy, orders processed and delivered to The Legacy of St. Michael, where a nurse reviews them and checks them in then locks them in medication cabinet and a trained home health aide administers them."

R8's NEW Nursing Assessment, dated October 13, 2022, identified as the 90-day assessment, included a Medication and Treatment Evaluation and Management Plan, which indicated all medications and treatments had been reviewed, face to face, with the resident and/or responsible party and medication administration was provided by community unlicensed staff. The plan noted the nurse was responsible for reordering medications from the pharmacy and medications were locked in R8's apartment. Also included, there was no change in the medication plan and specific instructions noted, "Refer to MAR for client [resident] receiving assist."

R8's prescriber orders, dated August 2, 2022, included R8's International Normalized Ratio (INR) results were 2.1 (normal 0.8-1.1), with orders to continue Coumadin (same as warfarin) (blood thinner) 2.5 milligrams (mg) by mouth Tuesday, Thursday, Saturdays, and Coumadin 1.25 mg by mouth on Monday, Wednesday, Friday, and Sunday, and an INR on August 23, 2022, and noted "(Lifespark [facility's onsite provider] will do)."

R8's Medication Administration Record (MAR), dated August 2022, indicated, effective July 19,

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2022, through August 2, 2022, warfarin 2.5 mg tablet by mouth on Tuesday, Thursday, and Saturday and warfarin 2.5 mg take 1/2 tablet (1.25 mg) by mouth on Monday, Wednesday, and Friday, and indicated INR August 2, 2022. The MAR also included, effective August 2, 2022, with an end date of August 23, 2022, warfarin 2.5 mg one tablet by mouth on Tuesday, Thursday, and Saturday, and warfarin 2.5 mg take 1/2 tablet (1.25 mg) by mouth on Sunday, Monday, Wednesday, and Friday, with INR on August 23, 2022. Initials were documented in each box, August 1, 2022, through August 23, 2022, indicating the warfarin was administered. There was no further documentation of warfarin administration until September 18, 2022, as noted on MAR dated September 2022.

Review of Medication Incident Report, dated September 17, 2022, at 6:00 p.m., identified the type of incident as "Missed Medication," and indicated R8's daughter reported R8 had an INR on August 18, 2022. The report indicated no orders were received by the facility, and R8 did not receive warfarin from August 23, 2022, through September 18, 2022. R8's daughter reported to the licensed practical nurse (LPN) that she "might not have brought to [sic] orders to the facility," and stated "do I have to?" The Incident Investigation indicated the LPN contacted the anticoagulant clinic and received new orders on September 19, 2022, and developed plan going forward. Order processing was updated with the pharmacy and pharmacy planned to profile any warfarin orders at 4:00 p.m. Services were updated to reflect changes along with an email to all nurses with this information.

R8's progress notes, dated August 18, 2022, at 4:41 p.m., indicated LPN-L received an after-visit

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summary from R8's daughter with instructions to continue Lasix (treat fluid retention) daily, limit sodium to less than 2000 milligrams daily, wear compression stockings on in the morning and off at bedtime, and to continue with daily weight. Also included, R8's daughter reported an INR was completed. R8's record lacked documentation of INR results or follow up with warfarin orders.

R8's progress notes, dated September 17, 2022, at 5:09 p.m., indicated R8 had an unwitnessed fall in her apartment and, due to findings of reddened areas on her head, family agreed to transport R8 to the hospital to be evaluated. At 9:34 p.m., staff received an update from R8's daughter who asked if R8 would be receiving her warfarin when she returned to the facility. LPN-L told R8's daughter that R8 was not currently taking warfarin. R8's daughter ensured LPN-L that R8 was still taking warfarin. LPN-L reviewed R8's nursing notes and noted R8 had a medical appointment on August 18, 2022. R8's daughter stated blood was drawn at the appointment. R8's daughter stated she may not have brought the orders to the nursing staff. LPN-L went to R8's apartment to look for the after-visit summary. CNS-B was notified via email of the missed medication and R8's daughter stated she would call CNS-B. On September 17, 2022, at 11:41 p.m., LPN-L called the hospital for another update and hospital nurse reported R8 had a urinary tract infection and may be discharged. On September 18, 2022, at 7:32 a.m., R8's daughter answered the door when staff went to check on R8 in her apartment, and reported R8 returned to the facility around 3:00 a.m. with new orders to contact primary care provider on Monday (September 19, 2022) to request prescription for warfarin, take antibiotic as ordered, take pain reliever as needed and use ice packs, and to

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follow up with PCP in 5-7 days. On September 18, 2022, at 10:41 a.m., triage registered nurse (RN) was contacted by the LPN and on-call physician was contacted. Orders were received to give warfarin 2.5 milligrams that evening and to call in the morning for further instructions. On September 18, 2022, at 12:15 p.m., triage RN documented she was contacted by nursing staff for guidance with above situation. Triage RN noted R8's INR was 1.1 (INR of 1.1 or below is considered normal) and indicated she encouraged nursing staff to reach out to primary clinic after hours on call, for guidance on Coumadin (same as warfarin). On September 19, 2022, at 2:04 p.m., RN-E documented the anticoagulation clinic would be faxing dosing of warfarin to the pharmacy and the facility today. On September 19, 2022, at 3:15 p.m., RN-E indicated she had discussed with CNS-B and R8's son about R8's missed warfarin, and noted R8's daughter had brought R8 to an anticoagulation clinic for her INR draw on August 18, 2022; however, the facility was not aware of which anticoagulation clinic R8 was brought to and did not receive new orders for warfarin dosing. R8's son was upset that R8 had missed her warfarin and that the facility had not contacted the anticoagulation clinic for orders. It was discussed that outside providers were required to fax orders to the facility or written orders must be brought to the facility to be able to order the medication from the pharmacy. Anticoagulation clinic was contacted by RN-E and requested orders be sent to pharmacy, as well as the facility. On September 19, 2022, at 8:13 p.m., LPN-L documented she contacted a nurse from the anticoagulation clinic and received orders for warfarin, and discussed the plan moving forward to prevent further issues. The nurse from the anticoagulation clinic explained R8's family had

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01760	Continued From page 71 canceled her services with them, and was the reason the orders were not communicated to the facility. On December 23, 2022, at 10:14 a.m., via telephone interview, CNS-B stated the facility's onsite provider was managing R8's warfarin and INR results; however, the family made the decision to utilize an outside anticoagulation clinic and didn't inform the facility of the change, therefore, the INR results did not get communicated to the facility and there were no warfarin orders. CNS-B indicated she didn't know how this was missed and stated this should have been followed up on and the medication plan should have been updated when changes were made. CNS-B stated reeducation was provided to nursing staff. The licensee's Medications and Treatments guideline, undated, noted the RN was responsible for assuring current, authorized prescriber orders for medications administered by the staff were kept on file in the resident's record and changes in orders were addressed in the resident's service plan and communicated to staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01920 SS=F	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that	01920		

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01920	Continued From page 72 when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement procedures for loss and spillage of all controlled substances defined in Minnesota Rules par 6800.4220. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 19, 2022, at approximately 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the licensee's residents. At this time, the surveyors requested to review the licensee's current	01920		

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01920	Continued From page 73 medication policies and procedures. On December 20, 2022, at 11:20 a.m., the surveyor observed the licensee's secure storage of controlled substances with licensed practical nurse (LPN)-G. The license's Medications & Treatments policy revision dated March 2021 noted under the last section titled disposal, instruction on what to do if a medication is dropped on the floor, including the resident would be allowed to take the medication after it is picked up with gloves on and wiped with a paper towel, or the medication could be disposed of. The provided policy had a handwritten note on the side "Spillage & Loss." However, the policy lacked the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting	01930		

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01930	Continued From page 74 treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written treatment and therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 19, 2022, at approximately 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy management services to the licensee's residents. At this time, the surveyors requested to review the licensee's current treatment and therapy policies and procedures. On December 19, 2022, at 11:51 a.m., licensed assisted living director (LALD)-A provided a survey binder, which contained several policies.	01930		

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01930	Continued From page 75 On December 20, 2022, at 8:50 a.m., the surveyor requested LALD-A provide all policies the licensee attested to having when they applied for the license, and all medication and treatment policies. The licensee lacked the following policies: - educating and communicating with residents about treatments or therapies they were receiving; - monitoring and evaluating the treatment or therapy; and - communicating with the prescriber. On December 22, 2022, at approximately 3:25 p.m., during a phone interview, LALD-A stated they would send them. However, policies related to the above were not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01930		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

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01940	Continued From page 76 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include the required content for one of five residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 19,	01940		

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01940	Continued From page 77 2022, at 10:20 a.m., clinical nurse supervisor (CNS)-B said the licensee provided treatment management services to the licensee's residents. R4's diagnoses included diabetes with hyperglycemia (high blood glucose levels) and long-term use of insulin. R4's Service Addendum to the Assisted Living Contract dated August 22, 2022, indicated R4 received services including assistance with toileting, transfers, medication administration, bathing, dressing, and blood glucose monitoring three times per day, at 8:00 a.m., 12:00 p.m., and at 4:00 p.m. R4's NEW Nursing Assessment, dated November 11, 2022, included under Medication and Treatment Evaluation and Management Plan, the nurse had reviewed all treatment and therapy services with the resident and/or resident's family. Also included, "BID [twice daily] blood sugar checks by Nurse and PRN [as needed] nystatin powder [antifungal] to skin under breasts when reddened." R4's Medication Administration Records (MAR), dated November 2022 and December 2022 included, "UNISTIK 3 MIS COMFORT [brand of lancets] USE AS DIRECTED TO TEST BLOOD SUGAR THREE TIMES DAILY." Documentation included blood sugar results at 8:00 a.m. and at 4:30 p.m.; however, the MAR lacked documentation of the results of the 12:00 p.m. blood sugar. R4's Physician Order Sheet, signed October 4, 2022, included, "Decrease BG [blood glucose] check to once daily in the evening."	01940		

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01940	Continued From page 78 On December 23, 2022, at 11:10 a.m., clinical nurse supervisor (CNS)-B indicated the order for R4's blood glucose testing had changed to decrease R4's blood sugar checks to once daily, in the evening, and stated she could not explain why the treatment management plan had not been revised to accurately reflect the current orders and the services being provided, and indicated the treatment management plan should have been updated. The licensee's Medications & Treatments policy dated revised March 2021 noted the treatment management plan would describe the treatment service provided and would be kept current and updated with any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced	02040		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 79 by: Based on [observation] interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: Survey staff requested a facility hazard vulnerability or safety risk assessment documentation, but the licensee did not provide the requested documentation. During interview on December 19, 2022, at 2:30 p.m.,the regional maintenance engineer (RME)-I stated they had not completed a hazard vulnerability assesment on and around the property. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In	02170		

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	29185	A. BUILDING: _____ B. WING _____	12/23/2022

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02170	Continued From page 80 addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized activity plan based on the activity evaluation, for five of five residents (R2, R3, R4, R5, and R6).	02170		

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02170	Continued From page 81 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2022. R2 R2's diagnoses included Alzheimer's disease. R2's unsigned Service Addendum to the Assisted Living Contract dated effective December 7, 2022, indicated R2 received services including assistance with medication administration, toileting, and bathing. R2's Resident Engagement Note dated July 19, 2022, noted R2 received assistance for things she liked to do, and noted activities were offered at various times of the day. R2's Social History & Life Pattern Questionnaire dated August 13, 2021, noted R2 was interested in board games, arts and crafts, exercise, music, and reading. R2's record lacked an individualized activity plan based on the activity evaluation that reflected R2's activity preferences and needs, as required. R3 R3's diagnoses included pancreatic cancer.	02170		

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02170	Continued From page 82 R3's Service Addendum to the Assisted Living Contract dated April 3, 2022, indicated R3 received services including assistance with medication administration, bathing, dressing, and grooming. R3's Resident Engagement Note dated December 1, 2022, noted R3 received assistance for things he liked to do, was very engaged in activity programs of interest, and enjoyed watching television. R3's record lacked a Social History & Life Pattern Questionnaire. R3's record lacked an individualized activity plan based on the activity evaluation that reflected R3's activity preferences and needs, as required. R4 R4's diagnoses included diabetes with hyperglycemia (high blood glucose levels) and long-term use of insulin. R4's Service Addendum to the Assisted Living Contract dated August 22, 2022, indicated R4 received services including assistance with toileting, transfers, medication administration, bathing, dressing, and blood glucose monitoring. R4's Social History & Life Pattern Questionnaire, dated June 14, 2022, noted R4 was interested in card games, board games, exercise, sports as a spectator, music, reading, and children related activities. R4's Resident Engagement Note dated July 12, 2022, indicated R4 liked to stay in her room, and was able to independently structure her own leisure time. It also stated she enjoyed	02170		

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02170	Continued From page 83 participating in activities, was very social and enjoyed visiting with others. R4's record lacked an individualized activity plan based on the activity evaluation that reflected R4's activity preferences and needs, as required. R5 R5's diagnoses included diabetes and Parkinson's Disease. R5's Service Addendum to the Assisted Living Contract, dated November 1, 2022, indicated R5 received services including assistance with toileting, transfers, bathing, monthly vital signs, and bedmaking. R5's Social History & Life Pattern Questionnaire, dated May 19, 2022, noted R5 was interested in board games, arts and crafts, exercise, sports played, music, reading, children related activities, pets, faith-based, and outings. R5's Resident Engagement Note dated May 25, 2022, indicated R5 enjoyed taking part in the life of the facility, but relied upon others for reminders of times and locations of activities. R5's record lacked an individualized activity plan based on the activity evaluation that reflected R5's activity preferences and needs, as required. R6 R6's diagnoses included chronic kidney disease, depression, anxiety, and peripheral vascular disease. R6's Resident Engagement Note dated May 25, 2022, indicated she enjoyed participating in activities and was very social and enjoyed visiting	02170		

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02170	Continued From page 84 with others. R6's Service Addendum to the Assisted Living Contract, dated August 16, 2022, indicated R6 received services including assistance with toileting, catheter care, transfers, bathing, dressing, grooming, hearing aid, monthly vital signs, and escort. R6's Social History & Life Pattern Questionnaire, dated August 17, 2022, noted R6 was interested in card games, sports as a spectator, music, reading, children related activities, pets, faith-based, outings, watching television, gardening, volunteer work, social events, and fishing. R6's record lacked an individualized activity plan based on the activity evaluation that reflected R6's activity preferences and needs, as required. On December 22, 2022, at approximately 1:35 p.m., clinical nurse supervisor (CNS)-B stated they did an evaluation, but said the licensee did not have a written activity plan for any of the residents. The licensee's Special Care Status Disclosure For Special Care/Memory Support Community at the Legacy of St. Michael, dated July 2021, indicated Community Life programs would be offered to residents of the Special Care/Memory Support Unit regularly in the morning, afternoon, and evening, which may include life enrichment activities such as music and spiritual care, entertainment, exercise, crafts and homemaking tasks, adapting activities to each individual's abilities. Also included, the licensee promoted a balanced calendar engaging all dimensions of wellness. The disclosure did not address the	02170		

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02170	Continued From page 85 requirement regarding an individualized activity plan must be developed for each resident based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical or nursing standards, for two of two residents (R6, R5) with hospital bed with bedrails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate order for correction on December 20, 2022.	02310	On December 21, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	

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02310	Continued From page 86 The findings include: R6 On December 20, 2022, at 10:06 a.m., the surveyor observed R6's bilateral bedrails affixed to the hospital bed. Both bedrails were in the raised position. The right bedrail was loose, being able to freely move from side to side and front to back. R6 stated she used the left bedrail to hold on to when transferring, but stated didn't usually use the right bedrail. R6 was admitted August 1, 2011, with diagnoses including history of deep vein thrombosis, impaired mobility, osteoarthritis, bilateral carpal tunnel syndrome, pain, anemia, stage 3 chronic kidney disease, and generalized anxiety disorder. R6's Service Addendum to the Assisted Living Contract, dated August 16, 2022, indicated R6 received services including bathing, dressing, grooming, medication administration, escort assistance, transfer assistance with sit to stand lift, toileting/incontinence assistance, catheter cares, housekeeping and laundry. R6's record included an Annual/Change in Condition Assessment, dated April 14, 2022, which lacked an assessment of bedrail usage. R6's record included a Side Rail Review-Maintenance, dated May 20, 2022, which indicated the bedrail was installed and used consistent with the manufacturer's recommendations, appeared to be in good condition, was sturdy and did not wobble, space between the bedrail and mattress did not exceed 4.75 inches, and the space within a section of a bedrail did not exceed 4.75 inches. In addition,	02310		

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02310	Continued From page 87 the review indicated the bedrails were inspected and met the Food and Drug Administration (FDA) non-entrapment dimensional guidance, and were signed by the registered nurse (RN). The back of the review included handwritten measurements for zones 1 through zone 7, indicating zone 1 (openings between the bars) measured 3.5 inches, zone 2 (under the rail) measured 3 inches, zone 3 (between the bedrail and the mattress) measured "none," zone 4 (under the bedrail, at the ends of the bedrail) measured "none," zone 5 (between split bedrails) measured "none," zone 6 (between the end of the bedrail and the headboard) measured 6.5 inches, and zone 7 (between the headboard and mattress) measured "none." R6's record included a Bed Rail and Assistive Devices Acknowledgement, signed by R6 on June 3, 2022, and a Physical Device Tool form, also dated June 3, 2022, indicating R6 acknowledged having received the facility's guidance on bedrails and assistive devices as well as the informational material published by the FDA. Also included, R6 had bilateral hospital bedrails on the bed, was assessed for entrapment risk, and had sufficient upper body strength to pull/push herself up from lying position with assist of one, as needed. R6's record included a NEW Nursing Assessment, identified as a 90-day assessment, dated August 8, 2022, and October 31, 2022, which each indicated R6 required assistance of two staff for transfers using sit to stand lift, and noted R6 had bilateral hospital bedrails, was alert and oriented, and used the bedrails due to weakness and impaired mobility as a mobility enabler/enhancer, for positioning and safety.	02310		

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02310	Continued From page 88 R6's record lacked a comprehensive assessment to include evidence of physical inspection of the bed rail and mattress for areas of entrapment and stability of the device, quarterly or with a change of condition, as required. R5 On December 20, 2022, at 9:41 a.m., the surveyor observed R5's bilateral bedrails were firmly affixed to the hospital bed. Both bedrails were in the raised position. R5 stated she used the bedrails to move from side to side in the bed and to sit up. R5 was admitted on April 28, 2022, with diagnoses including diabetes, Parkinson's Disease, rheumatoid arthritis, and recurrent dislocation of the right shoulder. R5's Service Addendum to the Assisted Living Contract, dated November 1, 2022, indicated R5 received services including toileting, bathing, and transferring with mechanical lift. R5's prescriber Discharge Orders, dated April 26, 2022, indicated R5 required a hospital bed. R5's Nursing Admission Assessment, dated April 22, 2022 (six days prior to admission), lacked an assessment of bedrail usage. R5's Physical Device form, dated May 6, 2022, indicated R5 had bilateral bedrails on the hospital bed, that aided in turning and repositioning, holding while getting out of bed or repositioning while in bed, providing a feeling of comfort and security and "can provide easy access to bed controls and personal care items." The form also included the risks of bedrail using including strangling, suffocating, bodily injury or death.	02310		

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02310	Continued From page 89 Further, the form included medical symptoms of weakness and fatigue, and the device would be used for a mobility enabler/enhancer and positioning. The form lacked measurements of the bedrails. R5's Comprehensive Assessment, dated May 19, 2022, and identified as the 14-day Review, lacked identification of or an assessment of the bedrails. R5's Side Rail Review-Maintenance, dated May 20, 2022, indicated the bedrail was installed and used consistent with the manufacturer's recommendations, appeared to be in good condition, were sturdy and did not wobble, space between the bedrail and mattress did not exceed 4.75 inches, and the space within a section of a bedrail did not exceed 4.75 inches. In addition, the review indicated the bedrails were inspected and met the FDA non-entrapment dimensional guidance, and were signed by the licensed practical nurse (LPN). The back of the review included handwritten measurements for zones 1 through zone 7, indicating zone 1 (openings between the bars) measured "3.5" inches, zone 2 (under the rail) measured "0" inches, zone 3 (between the bedrail and the mattress) measured "0" inches, zone 4 (under the bedrail, at the ends of the bedrail) measured "0," zone 5 (between split bedrails) measured "NA [not applicable]," zone 6 (between the end of the bedrail and the headboard) measured "3.5" inches, and zone 7 (between the headboard and mattress) measured "0" inches. R5's Bed Rail and Assistive Devices Acknowledgement, signed by R5 on June 3, 2022, and a Physical Device Tool form, also dated June 3, 2022, indicating R5 acknowledged having received the facility's guidance on bedrails	02310		

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02310	Continued From page 90	02310		

and assistive devices as well as the informational material published by the FDA. Also included, R5 had bilateral hospital bedrails on the bed, was assessed for entrapment risk, and had sufficient upper body strength to pull/push herself up from lying position.

R5's record included NEW Nursing Assessment, identified as a 90-day assessment, dated July 21, 2022, and October 18, 2022. Each indicated R5 required assistance of two staff for transfers using sit to stand lift, and noted R5 had bilateral hospital bedrails, was alert and oriented, and used the bedrails due to weakness and impaired mobility as a mobility enabler/enhancer, for positioning and safety.

R5's record lacked a comprehensive assessment to include evidence of physical inspection of the bed rail and mattress for areas of entrapment and stability of the device, quarterly or with a change of condition, as required.

On December 20, 2022, at 11:08 a.m., registered nurse (RN)-E stated the process of assessing a resident with bedrails included completing the forms, having the resident sign that they understand the risks of using the bedrails, and measuring the bedrail zones. RN-E stated she wasn't sure how often the bedrails were assessed, but stated, "I do them when I'm told to." RN-E stated she did an assessment this morning for R6 and R5 that included measurements "because they [management] told me to."

On December 20, 2022, at 1:29 p.m., clinical nurse supervisor (CNS)-B stated bedrails were assessed initially (when the resident moved in or obtained the bedrails), when the resident's

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02310	Continued From page 91 condition changed, or at a minimum, annually. CNS-B stated the 90-day assessments included questions to ensure the resident continued to be safe when using the bedrails; however, the nurses did not "put their hands on them," did not observe the bedrail, and did not assess the resident when using the bedrail, during the 90-day assessments. The licensee's Resident Assistive Devices policy, revised December 2022, indicated it was the general practice of the facility to not allow bedrails or other similar assistive devices; however, if the device was determined to benefit the resident, facility clinical staff would be responsible for completing the appropriate assessments and reviewing the risks and benefits of such devices with the resident and responsible party. Any device utilized by a resident shall have a monthly safety check scheduled to a facility nurse. These safety checks included the following: - Assistive device is secured to the bed frame and the device is in working order; - hospital bedrails cannot exceed 4.75 inches for zones 1 through 4; and - determine if device is still in the resident's best interest, PT/OT evaluation if changes were noted. The policy also included, "Facility's maintenance staff will be responsible for applying bed rail(s) and measurement of all areas/zones of risk to ensure the greatest safety possible with the bed rail(s). Maintenance will conduct ongoing testing of bed rail(s)/bed frame and mattress zones. Further, the policy noted the facility will adhere to the following assessment and monitoring schedule: - PT/OT evaluation for therapeutic placement of device; - Initial assessment of the devices - Nursing Assessment/Physical Device Tool; and	02310		

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02310	Continued From page 92 - Quarterly review of the device or with change of condition in Nursing Assessment and/or Physical Device Assessment. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: -Purpose and intention of the bed rail; -Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -The resident's bed rail use/need assessment; -Risk vs. benefits discussion (individualized to each resident's risks); -The resident's preferences; -Installation and use according to manufacturer's guidelines; -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When	02310		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 93 bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29185	A. BUILDING: _____ B. WING _____	12/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF ST MICHAEL	4400 LANGE AVENUE NE SAINT MICHAEL, MN 55376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 94	03000		

provisions of this section may voluntarily report as described above.
(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.
(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.
(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to immediately report an allegation of abuse to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R7).

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

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	29185	A. BUILDING: _____ B. WING _____	12/23/2022

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03000	Continued From page 95 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 19, 2022, at 10:20 a.m., the surveyor made a request to the licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, regional corporate nurse (RCN)-J, and assistant executive director (AED)-H to review a list of all resident incident reports and all of the vulnerable adult reports the licensee had made to MAARC in the past six months, to which they indicated one report had been submitted. On December 19, 2022, at 1:19 p.m., one MAARC report was provided to the surveyors, regarding suspected financial exploitation. The MAARC report was reported timely. On December 21, 2022, at 1:25 p.m., a Resident Incident/Accident list was provided, which included the date and time of the incident, the resident's name, and the type of incident that occurred, including categories of witnessed and unwitnessed falls, bruises, skin tears, and "other." The surveyor made a request to review a selected list of the incidents, including R7's incident report, dated August 30, 2022, at 2:00 p.m., identified as "other." R7's Resident Incident Report, completed on September 3, 2022, by licensed practical nurse (LPN)-D, indicated on August 30, 2022, at 2:00 p.m., R7 reported she did not remember the date of the incident, but reported a male caregiver touched her inappropriately while he applied	03000		

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	29185	A. BUILDING: _____ B. WING _____	12/23/2022

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03000	Continued From page 96	03000		

powder to her groin area. R7 reported the male caregiver stated he wanted to give her a massage, have a child with her, and asked her to come and visit him after he was done caring for other residents. R7 reportedly told the male caregiver that she would like to date first before doing anything like this with him. R7 stated the male caregiver laid in her bed with her and stated this was upsetting because she wanted to go on a date before doing anything sexual with him. R7 reported she texted her guardians the next day, telling them she wanted to go home. The incident report indicated R7's guardian, physician's assistant, and CNS-B were notified, and two registered nurses (RN) performed a physical exam, with no signs or symptoms of trauma or injury. The incident report included a section titled Incident Investigation, which included R7 had impaired mental status, impaired safety judgement, cognitive impairment, and behaviors, and indicated R7's services were reviewed, medications reviewed, service plan was revised, service schedule reviewed, documentation in the resident's progress notes, and physical evaluation was completed. Also included, staffing patterns were reviewed, staff education provided, case worker and care team were updated. The male caregiver was interviewed, as well as other caregivers.

Review of R7's Adverse Event Investigation, undated, indicated the incident was first reported by a physical therapist to CNS-B on August 30, 2022, at 11:00 a.m. R7 was examined by a RN with no observed signs of redness, irritation, or bruising, and no sign of injury. The male caregiver was interviewed and suspended pending investigation. R7's guardian was notified of the incident and the pending investigation. R7's provider was made aware of the situation, and

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	29185	A. BUILDING: _____ B. WING _____	12/23/2022

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03000	Continued From page 97 other employees were interviewed regarding interactions with R7 and the male caregiver. The summary and outcome of the investigative findings included, "Upon investigating incident and interview with [R7], it was discovered that this HHA [home health aide] [male caregiver] in question did not have access to R7's powders/creams and has not been assigned to administer medications to resident for over 3 months. ED [executive director] [LALD-A] interviewed [R7] regarding incident. Resident reports that HHA touched her inappropriately "the other day" while applying medication; however, HHA has not had access to this medication. Interview also provided conflicting information from resident." Also included, interviews with other employees determined that R7 had been sexually inappropriate at times with them, and had made sexual requests and comments. The summary included, "After resident exam, interview and employee interviews it was determined that HHA did not touch [R7] inappropriately." Review of R7's record indicated R7 was admitted to the facility on March 9, 2022, and had diagnoses including mild cognitive impairment, Wernicke-Korsakoff Dementia (a memory disorder resulting from vitamin B1 deficiency), adjustment disorder with mixed anxiety and depressed mood, alcohol abuse, and traumatic brain injury. R7's Service Addendum to the Assisted Living Contract, dated September 9, 2022, indicated R7 received services including assistance with transfers, bathing, in-room dining, dressing, grooming, behavior observation, toileting, and medication administration.	03000		

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03000	Continued From page 98 R7's Vulnerability Evaluation, dated March 7, 2022, indicated R7 was not able to report abuse or neglect, and interventions included monitoring resident and reporting concerns to nurse immediately. Also noted, R7 was considered vulnerable for abuse by others and had a history of sexual inappropriateness, and interventions included monitoring and redirecting resident from inappropriate conversations and physical inappropriateness with other residents or staff, and to report to nurse immediately. R7's progress notes lacked mention of the reported incident. On December 22, 2022, at 3:20 p.m., LALD-A indicated an investigation was conducted when R7 reported being touched inappropriately and the male caregiver was interviewed and was suspended, pending the investigation. LALD-A stated R7 was interviewed, as well as other residents and employees. LALD-A stated a MAARC report was not submitted and indicated she had talked to her supervisor and didn't feel that the incident was reportable or that filing a MAARC report was necessary. The licensee's Vulnerable Adult/Maltreatment-Communication, Prevention, and Reporting (626.557) policy, revised October 2022, indicated all residents are considered vulnerable and "Abuse must be reported," including any act against a vulnerable adult which constitutes a violation of Minnesota's criminal statutes, including assault and battery or criminal sexual conduct. Also included, "All staff of Facility shall immediately make a report to the Minnesota Adult Abuse Reporting Center (MAARC)," via the website or telephone. Further, "To the extent possible, the report must be of sufficient content	03000		

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03000	Continued From page 99 to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

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

Type: Full
Date: *12/19/22*
Time: 11:13:40
Report: 7989221251

Food and Beverage Establishment Inspection Report

Location:
The Legacy Of St Michael
4400 Lange Avenue Ne
St Michael, MN55376
Wright County, 86

Establishment Info:
ID #: 0038589
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634970171
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: 3 comp
Violation Issued: No

Hot Water: = at 173 Degrees Fahrenheit
Location: dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 156 Degrees Fahrenheit - Location: SOUP
Violation Issued: No

Process/Item: Hot Holding
Temperature: 189 Degrees Fahrenheit - Location: PORK
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: CUCUMBERS
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: HAM LUNCH MEAT
Violation Issued: No

Type: Full
Date: *12/19/22*
Time: 11:13:40
Report: 7989221251
The Legacy Of St Michael

Food and Beverage Establishment Inspection Report

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7989221251 of 12/19/22.

Certified Food Protection Manager: JOSHUA ORDOFF

Certification Number: 53552 Expires: 12/13/25

Signed: _____
Establishment Representative

Signed: Tyffani Maresh

Tyffani Maresh
Public Health Sanitarian
St Cloud
320-223-7361
Tyffani.Maresh@state.mn.us

Report #: 7989221251

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0	Date	12/19/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:13:40
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
The Legacy Of St Michael	4400 Lange Avenue Ne	St Michael, MN	55376	7634970171

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038589		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O — Proper cooking time & temperature		
19	IN OUT N/A N/O — Proper reheating procedures for hot holding		
20	IN OUT N/A N/O — Proper cooling time & temperature		
21	IN OUT N/A N/O — Proper hot holding temperatures		
22	IN OUT N/A — Proper cold holding temperatures		
23	IN OUT N/A N/O — Proper date marking & disposition		
24	IN OUT N/A N/O — Time as a public health control: procedures & records		
Consumer Advisory			
25	IN OUT N/A — Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26	IN OUT N/A — Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A — Food additives: approved & properly used		
28	IN OUT — Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29	IN OUT N/A — Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

		COS	R
Safe Food and Water			
30	IN OUT N/A — Pasteurized eggs used where required		
31	Water & ice obtained from an approved source		
32	IN OUT N/A — Variance obtained for specialized processing methods		
Food Temperature Control			
33	Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O — Plant food properly cooked for hot holding		
35	IN OUT N/A N/O — Approved thawing methods used		
36	Thermometers provided & accurate		
Food Identification			
37	Food properly labled; original container		
Prevention of Food Contamination			
38	Insects, rodents, & animals not present		
39	Contamination prevented during food prep, storage & display		
40	Personal cleanliness		
41	Wiping cloths: properly used & stored		
42	Washing fruits & vegetables		

		COS	R
Proper Use of Utensils			
43	In-use utensils: properly stored		
44	Utensils, equipment & linens: properly stored, dried, & handled		
45	Single-use/single service articles: properly stored & used		
46	Gloves used properly		
Utensil Equipment and Vending			
47	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	Warewashing facilities: installed, maintained, & used; test strips		
49	Non-food contact surfaces clean		
Physical Facilities			
50	Hot & cold water available; adequate pressure		
51	Plumbing installed; proper backflow devices		
52	Sewage & waste water properly disposed		
53	Toilet facilities: properly constructed, supplied, & cleaned		
54	Garbage & refuse properly disposed; facilities maintained		
55	Physical facilities installed, maintained, & clean		
56	Adequate ventilation & lighting; designated areas used		
57	Compliance with MCIAA		
58	Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/19/22

Inspector (Signature) Tiffany Mariel