Electronically Delivered

November 7, 2022

Administrator
Twin Town Villa
615 Durum Drive
Breckenridge, MN 56520

RE: Project Number(s) SL30535015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 26, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

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,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30535	A. BUILDING: _____ B. WING _____	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN TOWN VILLA	615 DURUM DRIVE BRECKENRIDGE, MN 56520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30535015 On, October 24, 2022, through October 26, 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 73 residents, 53 whom were receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the staffing plan was posted in the memory care unit, potentially affecting 17of the 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) and was issued at a widespread scope (when problems are pervasive	0 470		

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0 470	Continued From page 2 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). On October 24, 2022, at approximately 1:55 p.m., during a tour of the facility the surveyor did not observe a posted staff schedule during a tour of the locked memory care unit. On October 24,2022, at 2:01 p.m., licensed assisted living director (LALD)-A acknowledged the staffing schedule was only posted in the main entry and not posted for residents, staff, and visitors to be able to access in the locked memory unit. The licensee's Staffing, Direct Care Staffing Plan, and Daily Schedule policy, undated, indicated the LALD would post by day all work shifts including days and hours, and shifts would be documented on each department, and it would be updated with any changes that were needed. In addition, the daily work schedule would be posted in a central location in each building of a facility or campus accessible to staff, residents, volunteers, and the public. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	0 480		

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0 480	Continued From page 3 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 25, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 640	Continued From page 4	0 640		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in the memory care unit to include information and the number to report suspected maltreatment of a vulnerable adult. This had the potential to affect all 17 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). On October 24, 2022, at approximately 1:55 p.m., during a tour of the facility the surveyor did not observe the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected	0 640		

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0 640	Continued From page 5 maltreatment of a vulnerable adult in the locked memory care unit as required. On October 24,2022, at approximately 2:00 p.m., licensed assisted living director (LALD)-A verified the required information was not posted in the locked memory unit or on the second floor of the building. LALD-A commented, "this is why we do this [surveys], we are learning". The licensee's Required Postings policy, undated, indicated Minnesota Adult Abuse Reporting Center information and reporting number (1-844-880-1575) would be posted or displayed in the community. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	0 680		

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0 680	Continued From page 6 missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to post emergency exit diagrams in prominent areas in the locked memory care unit or on the second floor of the assisted living building. This had the potential to affect all residents receiving services under the assisted living with dementia license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 24, 2022, at approximately 1:55 p.m., during a tour of the facility the surveyor observed no signage of emergency exit diagrams in the locked memory care unit or on the facility's second floor of the assisted living. On October 24,2022, at 2:01 p.m., licensed	0 680		

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0 680	Continued From page 7 assisted living director (LALD)-A verified exit diagrams were not posted in the locked memory unit or on the second floor of the building. LALD-A commented, "this [posting exit diagrams] makes sense, this is why we do this [surveys]. The licensee's Required Postings policy, undated, indicated emergency exit diagrams would be posted or displayed on each floor. 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;	0 730		

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0 730	Continued From page 8 (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	0 730		

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0 730	Continued From page 9 The findings include: The licensee's Discharge Resident/Client Roster dated April 1, 2022, to October 24, 2022, indicated R2 was admitted on September 10, 2019, and discharged on June 1, 2022, to a nearby facility for a change in level of care. R2's diagnoses included hypertension (HTN-high blood pressure), osteoporosis (a condition where bones become weak and brittle), and compression fracture (a partial collapse of one or more of the bones of the spine). R2's service plan dated February 24, 2022, indicated R2 received the following services: medication administration, assistance with compression stockings, showering, housekeeping, and laundry. On October 24, 2022, at approximately 2:30 p.m., the surveyor asked for a copy of R2's discharge summary. R2's Discharge-Transfer Summary provided was dated as completed by registered nurse (RN)-C on October 24, 2022 (after the Minnesota Department of Health survey had been initiated). On October 26, 2022, at 9:56 a.m., RN-C stated the expectation is for the discharge summary to be completed by the RN within five days of the resident's discharge date. RN-C stated R2's discharge summary had been "overlooked" and that she had completed it after the surveyor had requested a copy. The licensee's Content of the Resident Record policy dated July 28, 2021, noted the resident's record would include a discharge summary.	0 730		

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0 730	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on October 24,	0 970		

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0 970	Continued From page 11 2022, at 1:44 p.m., the surveyor asked for a copy of the licensee's assisted living contract. The assisted living contract was provided to and later reviewed by the surveyor. The assisted living contract provided included a clause that indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. Page 15, section 27. Miscellaneous Provisions, item A. Complaint of the assisted living contract indicates as an occupant of the Community [facility], the resident assumes the risk for resident's own safety. Resident will indemnify and hold harmless Landlord [licensee], 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 Landlord's [licensee's] property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents. On October 26, 2022, at 9:39 a.m., the corporate director of nursing (CDN)-B stated the licensee provided the same template assisted living contract to all residents. CDN-B reviewed the Miscellaneous Provisions section of the assisted living contract noted above and stated he could see how this language could be interpreted in a way that did not meet the regulation. CDN-B stated they will have their lawyer review the contact and get it "fixed". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN TOWN VILLA	615 DURUM DRIVE BRECKENRIDGE, MN 56520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 12	01060		
01060 SS=E	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 returned to the facility within four days. (d) Following an emergency relocation, a facility's	01060		

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01060	Continued From page 13 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 required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for two of two residents (R2, 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 resident's health or safety) 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 The licensee's Discharge Resident/Client Roster dated April 1, 2022, to October 24, 2022, indicated R2 was admitted on September 10, 2019, and discharged on June 1, 2022, to a nearby facility for a change in level of care. R2's service plan dated February 24, 2022, indicated R2 received the following services: medication administration, assistance with compression stockings, showering, housekeeping, and laundry.	01060		

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01060	Continued From page 14 R2's Resident Notes noted: - May 7, 2022, at 8:20 a.m., resident had a fall this morning, is very confused, daughter updated and is going to bring R2 to the emergency room to be assessed. At 6:20 p.m., family called to update and R2 will be spending the night at the hospital, the hospital is running some tests and they will keep us [the facility] updated. - May 13, 2022, notification from registered nurse (RN) at [name of nearby hospital] that the resident will be transferred to [name of nearby facility] for rehabilitation services. The plan is for R2 to return to the facility after therapy. - May 16, 2022, ombudsman notification for transfer of care to [name of nearby rehabilitation facility]. R2's Discharge-Transfer Summary dated October 24, 2022, (completed after Minnesota Department of Health survey had been initiated) indicated R2 had moved to a skilled nursing facility on May 16, 2022, as resident required a higher level of care. R2's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact	01060		

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01060	Continued From page 15 information for the agency to which the resident may submit an appeal. In addition, R2's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On October 26, 2022, at 10:12 a.m., RN-C stated at the time R2 was sent to the hospital and then transferred to the nursing home, the facility did not have a clear understanding of the emergency relocation regulation. RN-C stated the emergency relocation written notice, nor the OOLTC notification had not been completed for R2 as required. R6 R6's service plan dated June 27, 2022, indicated R6 received the following services: pulse-daily, respirations-monthly, blood pressure-monthly, weight-monthly, bowel monitoring, temperature-daily, safety checks, shower assistance, toileting/resident location, transfer assist, wander guard, memory care level 1 package, and meal package. R6's Resident Notes noted: - August 2, 2022, resident admitted to (named) hospital for possible pneumonia. - August 8, 2022, resident transferred to a swing bed at (named) hospital, due to generalized weakness and deconditioning. Plan for daily physical therapy (PT) and occupational therapy (OT). - August 11, 2022, resident returned from hospital today after being admitted for pneumonia. R6's record included notification to the OOLCT dated August 8, 2022, (greater than four days).	01060		

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01060	Continued From page 16 R6's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On October 26, 2022, at 11:35 a.m., when RN-C bought the surveyor the "Cover Sheet for Notices from Assisted Living Facilities to the Office of Ombudsman for Long-Term Care (OOLTC)" form dated, August 8, 2022 for R6, RN-C confirmed the form did not contain all of the necessary information and the notification to OOLTC was sent late, "we [facility] are learning." The licensee's Termination of Residency-Emergency Relocation policy dated July 28, 2021, noted when the facility believes, and enacts emergency relocation of a resident, the facility much [sic] provide written notice to the residents, their legal representatives, and their designated representatives as soon as possible following the relocation. A copy of the written notice must also be provided to the resident's case manager if the resident is receiving assistance through waiver services. A copy of the notice of emergency relation [sic] will be provided to the Office of Ombudsman for Long-Term Care	01060		

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01060	Continued From page 17 within 24 hours if the resident has relocated and not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of five residents	01640		

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01640	Continued From page 18 (R10) service plan was revised to include provided services. 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: R10's diagnoses included Alzheimer's dementia, hypertension (HTN-high blood pressure), and gastroesophageal reflux disease (GERD-acid reflux). R10's Service Plan dated July 28, 2022, indicated the resident received the following services: morning (am) dressing, am grooming, bedmaking, housekeeping, laundry, life line check, meals, medication administration three times a day, nailcare, evening (pm) dressing, pm grooming, blood pressure-one day a week, oxygen saturation-daily, respiration-monthly, pulse-monthly, weight-every 14 days, bowel movement monitoring, temperature daily, safety checks, shower assistance, toileting, and wander guard. MEDICATION SET UP During the entrance conference on October 24, 2022, at 1:23 p.m. registered nurse (RN)-C stated medication set up services were provided for "a few: veterans, and two others." RN-C was asked	01640		

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01640	Continued From page 19 to identify on the resident roster which residents were receiving medication set up services. RN-C marked two names on the resident roster. On October 26, 2022, at approximately 9:55 a.m., the surveyor requested R10's medication set up documentation and later reviewed R10's medication set up documentation with RN-C On October 26, 2022, at approximately 10:15 a.m., RN-C verified R10's service plan had not been revised to include medication set up services. RN-C added in the memory care unit it does not change the fees. RN-C confirmed service plans are updated when a change in fees occurred in the memory care unit. PRESCRIBER ORDERED MONITORING R10's prescriber's order, dated October 19, 2022, included: -discontinue metoprolol succinate (heart medication) 25 milligrams (mg) due to hypotension (low blood pressure). "Continue to carefully monitor blood pressures and notify clinic if increase noted." On October 26, 2022, at approximately 11:00 a.m., RN-C stated if an order was received for increased monitoring more information would be requested from medical provider. On October 26, 2022, at approximately 11:10 a.m., RN-C stated she was not aware that service plans required revision to reflect prescriber's orders for monitoring. RN-C verified R10's service plan had not been revised when blood pressure monitoring increased. RN-C added the fees for services would not be affected in the memory unit as they would have been in the assisted living	01640		

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01640	Continued From page 20 unit, confirming services plans in the memory unit were not revised if fees had not been affected. RN-C confirmed she had directed staff to monitor R10's blood pressure three times a week. The licensee's Development of the Service Plan policy reviewed July 26, 2021, indicated the RN would develop a service plan, and the RN would work with the resident and/or the resident's responsible person to make any necessary adjustment in the service plan, such as the time and day of the week on which particular services would be provided. In addition, services may be initiated upon the responsible party's verbal agreement, pending a signature confirming agreement via fax or mail. The RN must review and revise the assessment of the resident's needs and the resident's service plan whenever there was an incident, such as a fall, or a change in the resident's condition. The resident's assessment and service plan must be reviewed and updated as needed, with changed in condition, and at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;	01750		

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01750	Continued From page 21 (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide specific resident instructions relating to the administration of medications for one of four residents (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's diagnoses included, heart failure, major depressive disorder, generalized anxiety disorder, dementia with behavioral disturbance, hypertension (HTN-high blood pressure) and anemia (lack of red blood cells in the blood, reducing oxygen flow to the body's organs). R5's Individualized Medication Management Plan dated September 28, 2022, indicated staff to administer medications per medical doctor (MD) orders. R5's prescriber's orders dated September 27, 2022, included Eucerin cream, topical, apply to	01750		

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01750	Continued From page 22 dry skin twice a day (bid) and twice a day as needed or desired (prn). R5's medication administration record for scheduled medications included, Eucerin cream, daily, 1 application twice a day. On October 25, 2022, at 8:16 a.m., the surveyor observed unlicensed personnel (ULP)-D remove Tylenol 650 milligrams (mg), buspirone (anxiety) 10 mg, levothyroxine (thyroid) 150 micrograms (mcg) and metoprolol (heart) 50 mg into a medication cup and administrator R5's morning medication at the dining room table. On October 25, 2022, at approximately 1:50 p.m., registered nurse (RN)-C confirmed R5's Eucerin cream order did not specific where cream was to be applied. RN-C added, R5's body is dry all over. On October 26, 2022, at 11:56 a.m., RN-C handed the surveyor a prescriber's order dated October 25, 2022, for R5 that indicated Eucerin cream was to be applied bid and prn to trunk, arms, and legs. The licensee's Medication Administration policy, undated, indicated the RN had developed written, specific instruction for each client for administering the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 23 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as directed for one of four residents (R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6's diagnoses included history of prostate cancer, atrial fibrillation (irregular often fast heartbeat), pacemaker, hypertension (HTN-high blood pressure) and heart disease. R6's Individualized Medication Management Plan	01760		

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01760	Continued From page 24 dated August 11, 2022, indicated staff to administer medications per medical doctor (MD) orders. On October 25, 2022, at 7:24 a.m., the surveyor observed unlicensed personnel (ULP)-D removed digoxin (heart medication that works by increasing myocardial contractility, increasing stroke volume and blood pressure, and reducing heart rate) 125 micrograms (mcg), prednisone (inflammation) 2 milligrams (mg), Senna-S (bowels) 8.6/50 mg, 2 tabs, Tylenol two 500 mg tablets from the medication cart and administer them to R6. R6's medication administration record (MAR) dated October 1, 2022, through October 25, 2022, included digoxin 125 mcg, 1 tab by mouth daily. Notify registered nurse (RN) "I'd (sic) heart rate less than 60 beats per minute" (bpm). Directly after the above observation ULP-D confirmed she had not taken R6's pulse prior to administering R6's morning medication. ULP-D added, "I am going to take it now." ULP-D removed a pulse oximeter (noninvasive device to monitor a person's oxygen saturation and/or pulse) from the medication cart, cleaned the monitor using an alcohol wipe and placed the monitor on one of R6's fingers. The monitor indicated R6's pulse was 58. On October 25, 2022, at 9:00 a.m., RN-C stated it was "odd" that R6's pulse had not been checked prior to medication administration, adding "you have to take pulse before giving medication." RN-C stated the protocol would be for staff to call RN with the pulse in this situation. On October 25, 2022, at approximately 1:30 p.m.,	01760		

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01760	Continued From page 25 the surveyor reviewed R6's Vital Sign Set dated October 1, 2022, through October 25, 2022. R6's pulse reading included: -October 2, 2022, pulse of 59; -October 10, 2022, pulse of 56: and -October 25, 2022, pulse of 58, but recorded at 59 for R6. On October 25, 2022, at 1:40 p.m., RN-C verified she had not been notified of R6's pulse reading noted above. In addition, R6's MAR dated October 1, 2022, through October 25, 2022, indicated R6 received digoxin daily. The licensee's Documentation of Medication Service on the MAR policy, undated, indicated staff would administer the medication according to the instructions on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup was completed accurately	01770		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN TOWN VILLA	615 DURUM DRIVE BRECKENRIDGE, MN 56520

(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
01770	Continued From page 26 and/or updated with changes for one of one resident (R10) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 October 24, 2022, at 1:23 p.m. registered nurse (RN)-C confirmed the licensee provided medication management services which included medication setup by the RN. RN-C identified on the resident roster which residents were currently receiving medication setup. R10's diagnoses included Alzheimer's dementia, hypertension (HTN-high blood pressure), and gastroesophageal reflux disease (GERD-acid reflux). R10's Service Plan dated July 28, 2022, indicated R10 received medication administration three times a day. R10's service plan did not include medication setup services. On October 26, 2022, at approximately 9:55 a.m., the surveyor requested R10's medication set up documentation. R10's Med Setup/Review Summary dated October 1, 2022, through October 31, 2022, included cranberry (supplement) 500 milligrams (mg) daily, Ensure (nutritional supplement) 1	01770		

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01770	Continued From page 27 bottle daily, Florajen 3 (probiotic) 390 mg daily, Ocuvite (eye health) 1 tab daily, omeprazole (GERD) 20 mg every 2 days, sertraline (depression) 25 mg daily, Bactrim (antibiotic) 800/160 mg daily for seven days, melatonin 3 mg at bedtime daily, metoprolol (heart) 50 mg at bedtime daily (October 1, 2022 through October 19, 2022) and simvastatin (high cholesterol) 40 mg at bedtime. R10's prescriber orders dated June 23, 2022, July 22, 2022, September 8, 2022, October 15, 2022, and October 19, 2022, included the above medications. On October 26, 2022, at 12:25 p.m., the surveyor reviewed R10's "Med Setup/Review Summary" dated October 1, 2022, through October 31, 2022, with RN-C. RN-C verified R10's medication set up documentation was not accurate. RN-C stated she would need to reach out to RTasks (software program in place) to correct the system wide issue, when unlicensed personnel (ULP) documented, they [ULPs] "were over-riding" the documentation the RN did when medication set up was completed. RN-C added R10 was getting her prescribed medications. MEDICATION CHANGES The "Med Setup/Review Summary" dated October 1, 2022, through October 31, 2022, included sertraline 25 mg daily and omeprazole 20 mg daily. In addition, medication setup documentation included metoprolol 50 mg at bedtime, October 1, 2022, through October 19, 2022. Prescriber's order dated September 8, 2022, included an increase, sertraline to 50 mg daily.	01770		

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01770	Continued From page 28 Prescriber's order dated October 5, 2022, indicated an increase of omeprazole to 40 mg daily: and decrease metoprolol XL to 25 mg daily. Prescriber's order dated October 19, 2022, included discontinue metoprolol succinate 25 mg. On October 26, 2022, at approximately 1:10 p.m., the surveyor reviewed the medications in R10's seven-day medication planner with an unidentified ULP. The seven-day planner included the medications and dosages currently prescribed. The licensee's Documentation of Medication Assistance policy, undated, indicated assistance with medication administration and medication administration would be documented on the medication administration record by entering the ULP's initials under the date and opposite the medication and dose given OR for active assistance with medications from the dosage box system, the aide would use the MAR for documenting medications given from a dosage box. The licensed nurse who sets up the mediations in the dosage box would review and monitor the past week's medication administration documentation and compliance and would initial that this has been done. The nurse would update and view the medication regimen when setting up medications. A licensed nurse would set up medications in dosage boxes for the resident, usually on a weekly basis, and would make changes between set ups when necessary. ULP's would verify medications are set up correctly in the dosage box before administration to the resident by using the medication profile.	01770		

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01770	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R3) who received treatments managed be the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on October 24, 2022, at 1:25 p.m., registered nurse (RN)-C	01970		

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01970	Continued From page 30 confirmed the licensee provided treatment and therapy services to residents. R3's diagnoses included atrial fibrillation (an irregular often fast heartrate), congested heart failure (CHF- condition in which the heart's function as a pump is inadequate to meet the body's needs), anxiety, depression, and chronic kidney disease. R3's service plan dated May 21, 2022, indicated R3 received assistance with thromboembolism-deterrent hose (TEDs - tight fitting stockings that place mild pressure on the legs to prevent the formation of blood clots) daily. R3's Treatment Recap Summary report dated October 1, 2022, through October 24, 2022, included documentation R3's TEDs had been applied in the morning and removed in the evening daily. R3's provider orders dated October 3, 2018, included an order for TED hose to be applied to R3's lower extremities to prevent lower extremity edema (swelling). On October 25, 2022, at 1:53 p.m., corporate director of nursing (CDN)-B stated the last order he could find for R3's TED hose was in 2018. CDN-B stated he was unaware that annual renewal orders needed to be obtained for TED hose as he thought they were a service that was provided and didn't see them as a treatment. The licensee's undated Renewal of Medication Orders policy indicated a medication or treatment order must be renewed at least every 12 months or more frequently as indicated by the nursing assessment.	01970		

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01970	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
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 by: Based on 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).	02040		

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02040	Continued From page 32 The findings include: A review of the Hazard Vulnerability Assessment showed global hazards such as fire, gas leaks, and epidemics but did not include hazards or safety risks identified on and around the property. During an interview on October 26, 2022, at 12:15 p.m., the Licensed Assisted Living Director (LALD) confirmed during an interview that the facility failed to include safety risks or hazards identified on and around the property in the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and	02170		

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02170	Continued From page 33 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 for one of two residents (R7) who resided in an assisted living with dementia care 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 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: R7's diagnoses included dementia with behaviors, coronary artery disease (CAD-damage	02170		

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02170	Continued From page 34 or disease in the heart's major blood vessels), hypertension (HTN-high blood pressure), and hypercholesterolemia (high cholesterol.) R7's Individual Activity Plan dated October 8, 2022, included an evaluation for activities to include: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; and -adaptations necessary for the resident to participate. R7's master care plan dated October 8, 2022, included: - physically aggressive, history of physical threats made towards staff and family; - verbally aggressive: verbally aggressive towards staff, residents, and family at times, staff to redirect as needed, provide as needed (PRN) medication for agitation; and - agitated at times. On October 26, 2022, at 11:29 a.m., registered nurse (RN)-C stated staff refer to the master care plan while working on the unit. RN-C indicated R7's activity plan and master care plan failed to identify activities for behavioral interventions. The licensee's Description of Life Enrichment Programs and How Activities are Implemented, undated, indicated each resident receiving assisted living services would be evaluated for activities, to include: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to	02170		

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02170	Continued From page 35 participate: and - identification of activities for behavioral interventions. In addition, this information would be shared with staff as they are oriented to the individual. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medication or nursing standards for one of five residents (R10) with medication management. 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:	02310		

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02310	Continued From page 36 R10's diagnoses included Alzheimer's dementia, hypertension (HTN-high blood pressure), and gastroesophageal reflux disease (GERD-acid reflux). R10's Service Plan dated July 28, 2022, indicated the resident received medication administration three times a day. R10's Individualized Medication Management Plan dated October 10, 2022, included: - staff to administer medications per medical doctor (MD) orders. Staff to report concerns to registered nurse (RN) for review; - med passers and licensed practical nurse (LPN)/RN to monitor medication supplies. LPN/RN to reorder medications when needed; - medications centrally stored in locked med cart. Extra supply of medication store in cupboard in locked medication room: - staff to call on-call RN. RNs are on-call 24 hours a day, 7 days a week. Staff to document refusals/ missed does and not notify on-call RN via Rtasks (electronic charting system) messaging of any medications declined or missed. Staff to notify on-call nurse of medication changes per MD orders. Staff to notify on-call nurse of any medication errors discovered. Staff to notify nurse of any witnessed interactions/side effects or change in resident cognitive status; - instructions provided to the resident and the resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; - the director of Health Services/RN, LPN, and/or Care Providers will be responsible for informing the pharmacy or family of any medication or supplies that are needed in a timely manner. The Care Provider staff will administer medications	02310		

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02310	Continued From page 37 delegated to them by the Director of Health Services/RN after they are determined to be competent to do so. Upon admission or with any new order changes that the resident is not on already, the Director of Health Services/RN will review face to face all medications including indications for use, side effects, contraindications, allergic, and adverse reactions with the resident and/or designated representative; and - med self-admin is not applicable. R10's prescriber orders dated July 22, 2022, included an order for melatonin (natural product used for sleep) 3 milligrams (mg) capsule, take 1 capsule by mouth at bedtime. R10's medication administration record (MAR) dated July 1, 2022, through July 31, 2022, indicated the melatonin 3 mg order was entered on July 25, 2022, at 1:00 p.m., and was first administered at 6:56 p.m., on July 25, 2022. On October 26, 2022, at 12:55 p.m., RN-C stated the order for melatonin was received on a Friday July 22, 2022, and not started until Monday July 25, 2022. On October 26, 2022, at 2:53 p.m., RN-C stated she was not working at the time the order for melatonin 3 mg order was received via fax on July 22, 2022. RN-C added, the on-call RN did not look in the right "spot" (place) for the faxed order. RN-C stated she "looked" for the melatonin order on Monday July 25, 2022, because she and the prescriber had discussed R10 starting on melatonin. RN-C and corporate director of nursing (CDN)-B mentioned it was possible the medication was not given because the medication may not have been "here" since R10's family "brings in her medication". CDN-B stated the	02310		

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02310	Continued From page 38 ULPs would have documented any behaviors or issues in their "shift notes" adding the shift notes are only kept for 30 days in Rtasks since they are not part of the resident's record. RN-C confirmed the prescriber had not been notified that melatonin was started three days after the order was written Nurse's notes dated July 1, 2022, to August 31, 2022, for R10 included: - July 22, 2022, (entered by RN-J) call received by unidentified unlicensed personnel (ULP), stated ULP received a bottle of melatonin for R10. "There is no order for this at present so will hold it till RN-C comes back on Monday. Nurse's note "entered" at 6:50 p.m. on July 22, 2022, nursing note read "occurred" at 6:00 pm. - July 25, 2022, "writer (RN-C) received new orders for melatonin per prescriber. Due to difficulty sleeping at night. "Writer reviewed face to face all medication with family including indication for use, side effects, contraindications, allergic and adverse reactions with family. All question answered. All medications will be stored in locked medication cart/cabinet. Discussion had with daughter regarding supplement." - August 3, 2022, included information regarding a new order for sertraline (depression, anxiety, panic disorder) due to anxiety. Melatonin was not named in any of the three other nurses notes written during this time span. On October 26, 2022, at 3:26 p.m., CDN-B stated he was unsure of what occurred regarding the melatonin 3 mg order. CDN-B stated the prescriber had now been updated of the July 22, 2022, order for melatonin was started on Monday July 25, 2022. In addition, CDN-B stated a medication error report was being completed for melatonin 3 mg and that documentation of	02310		

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02310	Continued From page 39	02310		

effectiveness of the medication did not occur. CDN-B confirmed the facilities medication policy and the Resident Handbook updated on May 2022, given to all residents, did not support R10's Individualized Medication Management Plan dated October 10, 2022.

The licensee's Implementation of Medication Orders policy, undated, indicated upon receipt of an order from an authorized prescriber, the licensed nurse or employee of the licensee must take action to implement the order with 24 hours, unless on a weekend when family will be responsible for medication order changes until the next tour of duty of the RN. If a licensed nurse is not on duty when an order is received, the staff will:
- notify RN within 1 hour of receipt of the order. If RN is not available, staff will leave voice message on answering machine describing order and resident involved.
- if it is at the end of a shift and staff have not received direction for the RN, the staff will make certain the next shift knows that a message had been left with the RN, what the message concerns and that you are awaiting direction from the RN.
- orders can only be implemented by unlicensed staff following direct contact with and direction by the RN. The LPN cannot delegate orders to unlicensed staff.
The original signed order or faxed order would be placed in a designated place for the nurse to review and sign. After the order had been implemented, the staff must document in the individual resident's log that orders were received, the RN was notified, and that the order was implemented via direct contact with the RN. The RN would add the order to the resident record in the appropriate place and would update

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30535	A. BUILDING: _____ B. WING _____	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN TOWN VILLA	615 DURUM DRIVE BRECKENRIDGE, MN 56520

(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 40 the service plan or other documents was necessary to reflect any changes in orders including documenting with each medication change that an assessment was done face to face with the resident. The RN would evaluate the effectiveness of the medication, treatment or therapy that had been prescribed or ordered and would report any concerns to the prescriber. The RN would monitor whether prescriptions and orders had been implemented as prescribed by: monitoring the client and the client's status and supervising unlicensed staff that are providing the medication, treatment or assigned therapy and review of relevant documentation and any complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30535	A. BUILDING: _____ B. WING _____	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN TOWN VILLA	615 DURUM DRIVE BRECKENRIDGE, MN 56520

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02410	Continued From page 41 in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure privacy was maintained for one of four residents (R7) observed during medication administration. 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: R7's diagnoses included dementia with behaviors, coronary artery disease (CAD-damage or disease in the heart's major blood vessels), hypertension (HTN-high blood pressure), and hypercholesterolemia (high cholesterol.) R7's Service Plan dated August 1, 2021, included medication administration up to three times a day.	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30535	A. BUILDING: _____ B. WING _____	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN TOWN VILLA	615 DURUM DRIVE BRECKENRIDGE, MN 56520

(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
02410	Continued From page 42 On October 25, 2022, at 7:43 a.m., R7 was seated in the open dining area that contained several tables. R7 was sitting at a table with one other resident. There were 4 residents in the dining area at that time. With gloved hands ULP-D approached R7 with a medication cup that contained R7's morning medication and a bottle of eye drops. ULP-D did not encourage, offer, or attempt to direct R7 to a private area. ULP-D took his oral medications. ULP-D handed R7 a tissue and administrated an eye drop into each of R7's eyes while R7 was seated at the table On October 25, 2022, at 9:00 a.m., registered nurse (RN)-C verified ULP-D should have offered R7 to go to his room or to give the eye drop medication later. The licensee's Eye Drop policy, undated, indicated staff was to provide privacy, and tell the individual what they were going to do. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		
02430 SS=D	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own	02430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30535	A. BUILDING: _____ B. WING _____	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN TOWN VILLA	615 DURUM DRIVE BRECKENRIDGE, MN 56520

(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
02430	Continued From page 43 records. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure resident's medical information was kept private. 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: On October 25, 2022, at 7:24 a.m., the surveyor observed unlicensed personnel (ULP)-D move the medication cart down the hallway of the memory unit and position the medication cart in the open dining area. ULP-D logged into the computer and brought up R6's medication administration record (MAR). ULP-D opened a drawer and removed R6's medications and put them into a medication cup. ULP-D took the medication cup to R6 and greeted him and asked him to take the medications. ULP-D stood near R6 until he swallowed all the medications. R6's MAR record remained visible on the computer screen. R9 was sitting in direct view of the computer screen. On October 25, 2022, directly following the above observation ULP- D stated she "normally" shuts the computer screen.	02430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30535	A. BUILDING: _____ B. WING _____	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN TOWN VILLA	615 DURUM DRIVE BRECKENRIDGE, MN 56520

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02430	Continued From page 44 On October 25, 2022, at 9:02 a.m., registered nurse (RN)-C verified the computer screen with medical information should not have been left in the open position. The licensee's Security of Resident Files policy dated July 28, 2021, indicated all information in the resident record is confidential and was accessible only to authorized personnel. In addition, the agency staff would not disclose to any other person and personnel, financial, medical, or other information about the client, except as may be required by law or by a court order; - to employees or contractors of the home care provider, another home care provider, other health care practitioner or provider, or inpatient facility needing information in order to provide services to the client, but only such information that was necessary for the provision of services; - to persons authorized in writing by the client or the client's representative to receive the information, including third-party payers; - to representatives of the Minnesota Department of Health authorized to survey or investigate home care providers; and - contractors who are given access to personal, financial, medical, or other information about the client must agree in writing to keep those records secure and confidential and follow agency's procedures. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *10/25/22*
Time: 08:30:27
Report: 7935221274

Food and Beverage Establishment Inspection Report

Location:
Twin Town Villa
615 Durum Drive
Breckenridge, MN56520
Wilkin County, 84

Establishment Info:
ID #: 0038423
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186439542
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.

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

DO NOT STORE RAW EGGS OVER READY-TO-EAT FOODS. PERSON IN CHARGE MOVED EGGS TO BOTTOM OF COOLER DURING INSPECTION.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

RAN OUT OF TEST STRIPS FOR DISH MACHINE YESTERDAY. NEW ONES HAVE BEEN ORDERED AND WILL BE DELIVERED THURSDAY. CONCENTRATION WAS GOOD ON DISH MACHINE FINAL RINSE.

Comply By: 10/28/22

Surface and Equipment Sanitizers

Chlorine: = 50 ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Aurora Cooler
Violation Issued: No

Type: Full
Date: *10/25/22*
Time: 08:30:27
Report: 7935221274
Twin Town Villa

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Bev Air Cooler
Violation Issued: No

Process/Item: Cooking
Temperature: 206 Degrees Fahrenheit - Location: Mixed Veggies
Violation Issued: No

Process/Item: Cooking
Temperature: 176 Degrees Fahrenheit - Location: Eggs
Violation Issued: No

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

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

5. Eggs served to a susceptible population should be pasteurized. If they are not pasteurized, they must be cooked to approved temperature and cooked for one individual for immediate service.

Type: Full
Date: *10/25/22*
Time: 08:30:27
Report: 7935221274
Twin Town Villa

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MN Department of Health inspection report number 7935221274 of 10/25/22.

Certified Food Protection Manager: Brooke Elizabeth Thomas

Certification Number: 105244 Expires: 12/17/23

Signed: _____
Establishment Representative

Signed: 7935
7935

651-201-4500
health.foodlodging@state.mn.us