Electronically Delivered

September 21, 2022

Administrator
Newton Manor
10000 Newton Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL21010015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 25, 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,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21010	A. BUILDING: _____ B. WING _____	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: PROJECT # SL21010015 On August 22, 2022, through August 25, 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 44 residents; 18 of whom were receiving services under the provider's Assisted Living 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. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to	

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0 000	Continued From page 1	0 000	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 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	0 470		

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0 470	Continued From page 2 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 interview and record review, the licensee failed to ensure that one or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents, were 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. 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 3 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 held an assisted living facility license with a bed capacity of 50 residents; current census was 44 residents. During the entrance conference on August 22, 2022, at 11:00 a.m. registered nurse (RN)-J stated beside nursing coverage during the day Monday through Friday, there was typically one unlicensed personnel (ULP) from 6:30 a.m. to 2:30 p.m. and one ULP from 3:30 p.m. to 10:00 p.m. each day. RN-B further stated on those two shifts, there was also one ULP who worked at the attached assisted living (The Commons) that would be available to help out should the assigned staff need assistance. RN-B confirmed there was not a ULP staff scheduled to work at Newton Manor from 2:30 p.m. to 3:30 p.m. and also on the overnight shift from 10:00 p.m. until 6:30 a.m. During those times the ULP from the attached assisted living responded. During the facility tour on August 22, 2022, at 11:57 a.m. licensed assisted living director (LALD)-A confirmed after reviewing the staff posting there was no evidence of any staff covering Newton Manor from 2:30 p.m. to 3:30 p.m. and from 10:00 p.m. until 6:00 a.m. LALD-A further confirmed the staff from The Common assisted living responded to any call lights at Newton Manor during that time; this was not reflected on the staff posting. On August 22, 2022, at 1:30 p.m. clinical administrator (CA)-B confirmed staff from The	0 470		

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0 470	Continued From page 4 Commons assisted living (a separate license) were responsible for answering call lights at Newton Manor from 2:30 p.m. to 3:30 p.m. and also during the overnight shift from 10:00 p.m. until 6:30 a.m. CA-B further confirmed their call lights were interchanged. CA-B stated to her knowledge they did not have a waiver to utilize staff from The Commons for Newton Manor. The licensee's Direct-Care Staffing Plan dated August 12, 2021, identified between the hours of 10:00 p.m. and 6:00 a.m. there would be direct-care staff able to respond to a resident's request for assistance with health and safety needs within a reasonable amount of time. These staff would be located in the same building, an attached building, or on a contiguous campus within the facility in order to respond within a reasonable amount of time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment	0 550		

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0 550	Continued From page 5 to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 22, 2022, at 11:57 a.m. the surveyor toured the facility with licensed assisted living director (LALD)-A. There were postings by the front entrance and a bulletin board on the wall down the hall with the month's menu, activity schedule and other events; however, there was no evidence of the grievance procedure or contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. At that time, LALD-A confirmed the content noted above was not posted as required. LALD-A stated there	0 550		

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0 550	Continued From page 6 had been recent remodeling in the building and the postings may not have gotten hung back up after completion. The licensee's Assisted Living Required Postings and Disclosures policy undated, identified postings required: grievance procedure (conspicuous location). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. This had the potential to affect all residents, staff, and visitors.	0 640		

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0 640	Continued From page 7 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 August 22, 2022, at 11:57 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A, and the facility observed to lack a posting of the MAARC hotline in the common areas of the facility. LALD-A confirmed this finding and indicated there had been recent remodeling in the building and the posting may not have gotten hung back up after completion. The licensee's Assisted Living Required Postings and Disclosures policy undated, identified postings required: MN Adult Abuse Reporting Center Information and reporting number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:	0 650		

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0 650	Continued From page 8 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content for one of one employee (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 650		

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0 650	Continued From page 9 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F had a start date of February 15, 2021. On August 24, 2022, at 8:54 a.m. ULP-F was observed to check R4's blood sugar and administer medications. ULP-F's record lacked evidence of the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs. On August 24, 2022, at 12:26 p.m. clinical administrator (CA)-B verified ULP-F had not had a performance review since she had started 18 months ago. CA-B further indicated all employees should have a performance review yearly. The licensee's Employee Handbook policy dated July 1, 2017, noted employees would be evaluated on the key result areas for the position, as well as: personal vision, personal leadership, personal management, interpersonal leadership, and communication. As a general rule, a review would take place annually on or about the anniversary of the hire date or the date of the most recent position change. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for one of three employees (unlicensed personnel (ULP)-F) with records reviewed. In addition, the licensee failed to ensure TB training was completed for one of three employees (registered nurse (RN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 660		

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0 660	Continued From page 11 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB facility risk assessment dated July 21, 2022, identified the licensee was low risk. TB TESTING ULP-F had a hire date of February 15, 2021, and started providing services under the licensee's assisted living license on August 1, 2021. On August 24, 2022, at 8:54 a.m. ULP-F was observed to check R4's blood sugar and administer medications. ULP-F's employee record contained a TB symptom screen dated January 28, 2021; however, ULP-F's record lacked evidence TB testing had been completed upon hire. On August 24, 2022, at 3:10 p.m. clinical administrator (CA)-B stated ULP-F was hired when TB testing had been deferred due to Coronavirus disease 2019 (COVID-19). CA-B stated once the deferment was lifted, ULP-F should have had the TB testing completed as all employees need to have a TB screening and testing prior to working with the licensee's residents. TB TRAINING RN-D had a hire date of September 2, 2021, to provide on-call triage services for the licensee's assisted living license. RN-D's employee record lacked documentation of	0 660		

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0 660	Continued From page 12 training related to TB. On August 25, 2022, at 1:00 p.m. CA-B confirmed RN-D had not had the required TB training. The licensee's Tuberculosis Control Plan policy undated, noted all employees will receive baseline TB screening prior to employment. Baseline TB screening will consist of two components: (1) assessing for current symptoms of active TB disease and (2) using a single interferon gamma release assay (IGRA) blood test or a two-step TST to test for infection with tuberculosis. In addition, the policy noted all employees receive information about tuberculosis upon hire and annually thereafter. This includes signs and symptoms, transmission, and treatment. Employees are informed of TB testing requirements and their roles and responsibilities All training records are maintained and filed in employee personnel file and/or the Learning Management System as applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 730		

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0 730	Continued From page 13 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 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:	0 730		

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0 730	Continued From page 14 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 (R3) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's record lacked a discharge summary to include: - diagnoses; - course of illness; - 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. R3 began receiving services on March 9, 2022, and was discharged on July 3, 2022. R3's record contained a form titled Discharge Summary, that included the resident's name, date services were initiated, discharge date, reason for initiation of services, summary of services provided during course of services, reason for discharge, condition upon discharge, status of	0 730		

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0 730	Continued From page 15 medications upon discharge, and a signature of the person preparing the summary. On August 24, 2022, at 10:30 a.m. clinical administrator (CA)-B indicated an old discharge summary form was utilized and verified it lacked the required discharge summary content. The licensee's MN AL Discharged Resident policy revised August 5, 2021, noted the nurse would complete the discharge summary and chart would be audited to ensure discharge summary components were completed; resident name, record number, address, dates of service and discharge, reason for initiation of services, summary of services provided, reason for discharge, client's condition upon discharge and status of medication. The policy did not include the required content of the discharge summary. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.	0 900		

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0 900	Continued From page 16 (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for two of two residents (R2, R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 900		

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0 900	Continued From page 17 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 and R1 began receiving services under the assisted living licensure on August 1, 2021, and May 4, 2022, respectively. R2 R2's Service Plan dated August 1, 2022, noted services included medication monitoring/management, treatment assistance and assistance with showering. On August 22, 2022, at 2:56 p.m. R2 confirmed the nurse filled her medication container weekly and she also received assistance with her weekly shower and applying/removing her Velcro leg wraps daily. R2 was observed wearing her Velcro leg wraps during the interview. R2's record lacked an assisted living contract. R1 R1's Service Plan dated August 9, 2022, noted services included medication administration, treatment assistance and assistance with activities of daily living. On August 23, 2022, at 9:35 a.m. R1 was observed receiving medications administered by unlicensed personnel (ULP)-C. R1's record lacked an assisted living contract. On August 23, 2022, at 8:35 a.m. licensed assisted living director (LALD)-A and clinical administrator (CA)-B stated because admissions were directed by HUD (United States Department	0 900		

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0 900	Continued From page 18 of Housing and Urban Development), they did not have a new assisted living contract for any of the residents as of yet. LALD-A stated their lawyer had been working with HUD and MDH (Minnesota Department of Health) to come up with a contract where they could "meet in the middle" with the contract language, but it had not yet been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01060 SS=D	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	01060		

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01060	Continued From page 19	01060		

information for the agency to which the resident may submit an appeal.
(c) The notice required under paragraph (b) must be delivered as soon as practicable to:
(1) the resident, legal representative, and designated representative;
(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and
(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.
(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1) 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:

R1's Physician Orders for Admission signed

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01060	Continued From page 20 March 16, 2022, indicated the resident was appropriate for an assisted living community and was able to self-administer her medications. R1 admitted for assisted living services on May 4, 2022. R1's Service Plan effective May 4, 2022, indicated R1 received services for treatment assistance, assistance with activities of daily living, and unlimited escorts. On August 23, 2022, at approximately 3:30 p.m. clinical administrator (CA)-B stated R1 had moved into the assisted living on March 12, 2022, and was admitted to the hospital on March 17, 2022, for a planned hip replacement surgery. CA-B further stated R1 had complications following the surgery, and went to the transitional care unit (TCU) prior to returning to the assisted living facility on May 4, 2022. R1's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060		

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01060	Continued From page 21 On August 24, 2022, at 9:00 a.m. CA-B confirmed a written notice related to R1's emergency relocation had not been completed, and further lacked notification to the Office of Ombudsman for Long-Term Care within four days that R1 had been relocated and had not returned to the facility. The licensee's Housing Termination, Relocation, and Transfer Policy and Procedure updated August 1, 2022, indicated: 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 but may trigger a termination as set forth below. 1. To do so, the facility must provide a written notice that states: a. the reason for the relocation; b. the name and contact information for the location to which the resident has been relocated and any new service provider; c. contact information for the Office of Ombudsman for Long-Term Care; d. 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 e. 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. 2. The notice required under paragraph 1 above must be delivered as soon as practicable to: a. the resident, legal representative, and designated representative; b. for resident who EW (Elderly Waiver) and CADI (Community Access for	01060		

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01060	Continued From page 22 Disability Inclusion), the resident's case manager; and c. the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not return to the facility within four days. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of three employees (unlicensed personnel (ULP)-F, ULP-E, and registered nurse (RN)-D). This practice resulted in a level two violation (a	01290		

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01290	Continued From page 23	01290		

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:

ULP-F
ULP-F was hired on February 15, 2021, and started providing direct care and services to the licensee's residents under the assisted living license on August 1, 2021.

On August 24, 2022, at 8:54 a.m. ULP-F was observed to check R4's blood sugar and administer medications.

ULP-F's employee record contained a background study dated February 17, 2021, for a separate location operated by the licensee's owner. ULP-C's employee record lacked evidence the licensee affiliated a background study for their license.

ULP-E
ULP-E was hired on January 17, 2022, to provide direct care and services to the licensee's residents.

ULP-E's employee record contained a background study dated January 17, 2022, for a separate location operated by the licensee's owner. ULP-E's employee record lacked evidence the licensee affiliated a background study for their

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01290	Continued From page 24 license. RN-D RN-D was hired on September 2, 2021, to provide on-call services to the licensee's residents. RN-D's employee record contained a background study dated September 22, 2021, for a separate location operated by the licensee's owner. RN-D's employee record lacked evidence the licensee affiliated a background study for their license. On August 24, 2022, at 1:35 p.m. clinical administrator (CA)-B confirmed ULP-F, ULP-E, and RN-D all had background studies submitted under different licenses and they had not been affiliated to the licensee's assisted living facility license. The licensee's Background Check policy dated April 13, 2018, included: All applicants for employment are required to disclose all crimes of which they have been convicted, other than minor traffic offenses, and to authorize [The Licensee] or its agent to conduct a criminal background check. Likewise, any employee who seeks to transfer to or add an alternate job or site with [The Licensee] for which a background check is required by law will be subject to the required criminal background check. All offers of employment are contingent upon the individual's consent to and successful completion of a criminal background check. Current employees may also be subject to periodic background checks during their employment as required or permitted by law and with the approval of Human Resources. No further information was provided.	01290		

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01290	Continued From page 25 TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy;	01370		

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01370	Continued From page 26 (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F's record lacked evidence of the following education and/or competencies had been completed prior to providing direct cares: - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; and - awareness of confidentiality and privacy ULP-F had a hire date of February 15, 2021, and started providing services under the licensee's Assisted Living license on August 1, 2021.	01370		

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01370	Continued From page 27 On August 24, 2022, at 8:54 a.m. ULP-F was observed to check R4's blood sugar and administer medications. ULP-F's employee record contained transcripts of courses completed, but lacked evidence of the above required training. On August 25, 2022, at 1:00 p.m. clinical administrator (CA)-B verified the above topics were lacking from ULP-F's employee file. CA-B indicated required courses were automatically assigned, but ULP-F had not completed them. The licensee's Education & Training policy revised April 2022, noted [the licensee] would support employees in maintaining and enhancing their professional competence across various practice settings by offering onboarding, training & continuous education activities that enable employees to: 3. Meet regulatory requirements The policy further included employees would receive orientation and ongoing training to assure they possessed the competencies and skill sets necessary to provide services to meet the residents' needs safely and in a manner that promotes each residents; rights, physical, mental and psychosocial well-being. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380		

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01380	Continued From page 28 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations contained all the required training prior to providing direct care for one of two unlicensed personnel (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F's employee record lacked evidence to indicate the employee's completed training and/or	01380		

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01380	Continued From page 29 practical skills evaluations as required in the following areas prior to providing direct care services: - recognizing physical, emotional, cognitive, and developmental needs of the client ULP-F had a hire date of February 15, 2021, and started providing services under the licensee's Assisted Living license on August 1, 2021. On August 24, 2022, at 8:54 a.m. ULP-F was observed to check R4's blood sugar and administer medications. ULP-F's employee record contained transcripts of courses completed, but lacked evidence of the above required training. On August 25, 2022, at 1:00 p.m. clinical administrator (CA)-B verified the above topic was lacking from ULP-F's employee file. CA-B indicated required courses were automatically assigned, but ULP-F had not completed all of them. The licensee's Education & Training policy revised April 2022, noted [the licensee] would support employees in maintaining and enhancing their professional competence across various practice settings by offering onboarding, training & continuous education activities that enable employees to: 3. Meet regulatory requirements The policy further included employees would receive orientation and ongoing training to assure they possessed the competencies and skill sets necessary to provide services to meet the residents' needs safely and in a manner that promotes each residents; rights, physical, mental and psychosocial well-being.	01380		

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01380	Continued From page 30 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470		

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01470	Continued From page 31 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of three employees (registered nurse (RN)-D, and unlicensed personnel (ULP)-F) received orientation to assisted living facility licensing requirements and regulations before providing 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	01470		

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01470	Continued From page 32 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: RN-D RN-D was hired on September 2, 2021, to provide on-call services to the licensee's residents. RN-D's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470		

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01470	Continued From page 33 other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-F ULP-F was hired on February 15, 2021, and started providing direct care and services to the licensee's residents under the assisted living license on August 1, 2021. On August 24, 2022, at 8:54 a.m. ULP-F was observed to check R4's blood sugar and administer medications. ULP-F's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an overview of this chapter; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; On August 25, 2022, at 1:00 p.m. clinical administrator (CA)-B verified RN-D and ULP-F lacked the required training. CA-B indicated there was a process for new employees to complete all aspects of the required training now, but it had not been done for employees hired prior to 2022. The licensee's Education & Training policy revised April 2022, included: employees will receive orientation and ongoing training to assure they possess the competencies and skill sets necessary to provide services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being.	01470		

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01470	Continued From page 34 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure three of	01530		

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01530	Continued From page 35 three employees (unlicensed personnel (ULP)-F, ULP-E, and registered nurse (RN)-D) received the required amount of dementia care training in the required time frame. 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: The licensee provided services under an Assisted Living license. ULP-F ULP-F was hired on February 15, 2021, and started providing direct care and services to the licensee's residents under the assisted living license on August 1, 2021. On August 24, 2022, at 8:54 a.m. ULP-F was observed to check R4's blood sugar and administer medications. ULP-F's employee record contained evidence the employee received one hour of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. ULP-E ULP-E was hired on January 17, 2022, to provide direct care and services to the licensee's	01530		

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01530	Continued From page 36 residents. ULP-E's employee record contained 4.5 hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. RN-D RN-D was hired on September 2, 2021, to provide on-call services to the licensee's residents. RN-D's employee record contained zero hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. On August 25, 2022, at 1:00 p.m. clinical administrator (CA)-B verified the above-named employee files lacked the required amount of training in dementia care and confirmed all employees had worked more than 160 hours. CA-B further stated the employees had been assigned the required training, but had not completed it. The licensee's Dementia Training policy dated August 1, 2021, noted initial orientation dementia training would include: i.) An explanation of Alzheimer's disease and other dementia's ii.) Assistance with activities of daily living iii.) Problem solving with challenging behaviors iv.) Communication skills v.) Person-centered planning and service delivery Employees who have not completed their initial dementia care training will not provide direct care independently. There will be another employee onsite while this employee is working who:	01530		

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01530	Continued From page 37 i.) Has completed the initial eight hours of training on topics related to dementia care ii.) Will serve as a resource for the employee who has not completed all of the initial dementia training A trainer or supervisor will be available for consultation with the new employee until the training requirement is complete. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or	01700		

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designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for two of two residents (R1, R2), prior to providing medication management 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:

During the entrance conference on August 22, 2022, at approximately 11:00 a.m. RN-J confirmed the licensee provided medication management services to many of the residents receiving assisted living services.

R1
R1's diagnoses included, right hip replacement, hypertension (high blood pressure), depression, hyperlipidemia (high cholesterol), lumbar spinal

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stenosis, chronic lower back pain, osteoporosis (a disease that weakens bones to the point where they break easily), and psoriasis (a skin disease that causes a rash with itchy, scaly patches, most commonly on the knees, elbows, trunk and scalp).

R1's Service Plan Agreement dated August 9, 2022, indicated R1 received medication monitoring/management and medication administration.

R1's prescriber orders signed May 11, 2022, included the following medications: two antidepressants, one anti hypertensive, one muscle relaxant, one anticonvulsant utilized for neuropathic pain, three supplements utilized for osteoporosis, one antihyperlipidemic, and one topical dermatological - antipsoriatic agent for psoriasis.

On August 23, 2022, at 9:35 a.m. the surveyor observed unlicensed personnel (ULP)-C administering R1's scheduled AM medications.

R1's record lacked evidence the RN conducted a face-to-face review of all medications R1 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.

On August 23, 2022, at 12:28 p.m. clinical administrator (CA)-B confirmed a face-to face medication management assessment including all the required content as noted above had not been performed for R1.

R2
R2's diagnoses included, chronic pain, hypertension, edema, allergic rhinitis (disorder

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NEWTON MANOR	10000 NEWTON AVENUE SOUTH BLOOMINGTON, MN 55431

(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
01700	Continued From page 40	01700		

caused by allergy-causing substance, called allergens, common symptoms include sneezing and runny nose) gastroesophageal reflux disease (GERD-hearburn), cataracts (a condition affecting the eye that causes clouding of the lens).

R2's prescriber orders signed December 20, 2021, included the following medications: one diuretic (water pill), one potassium supplement, two analgesic and one anticonvulsant to treat chronic pain, one antihypertensive, two ophthalmic eye drops to treat cataracts, one gastric acid secretion reducer to treat GERD, and one antihistamine to treat allergic rhinitis.

On August 22, 2022, at 2:56 p.m. R2 confirmed the nurse set up her medications weekly; a medi-minder was observed on R2's kitchen table.

R2's record lacked evidence the RN conducted a face-to-face review of all medications R2 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.

On August 24, 2022, at 11:07 a.m. CA-B confirmed a face-to face medication management assessment including all the required content as noted above had not been performed for R2.

The licensee's Medication Management Policy updated July 18, 2022, indicated a RN will conduct a face-to-face assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications and whether secured storage is appropriate given the resident's functional and cognitive status, concerns about the potential for drug diversion or other considerations. Based on this assessment, the

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01700	Continued From page 41 RN will develop and individualized medication management plan for the resident that will address storage of the resident's medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
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; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure delegated procedures were followed for one of three residents (R1) 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	01750		

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01750	Continued From page 42	01750		

limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's registered nurse (RN) 90-day assessment dated August 3, 2022, indicated the resident could correctly administer eye drops or ointments; this did not include oral medications.

R1's Service Plan Agreement dated August 9, 2022, indicated the resident received medication administration services provided by unlicensed personnel (ULP) three times daily.

On August 24, 2022, at 9:57 a.m. ULP-F was observed bringing R1 her medications that had been placed in a medication cup, to the resident in her living room. ULP-F placed the medications and a bottle of water on the side table next to where R1 was sitting, then asked if she needed anything else. R1 stated she already had water so ULP-F could put the water bottle back in the refrigerator. ULP-F returned the water bottle to the refrigerator then exited the apartment without watching R1 take her medications. R1 stated, "She usually stays and watches me take my medications, but since you're here she didn't".

On August 24, 2022, at 2:00 p.m. clinical administrator (CA)-B confirmed R1 did not have an order to administer her oral medications independently once set up by staff. CA-B further confirmed she would have expected ULP-F to stay and observe R1 take the medications prior to exiting the apartment.

On August 24, 2022, at 2:13 p.m. ULP-F stated she didn't think she had to stay and watch R1

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01750	Continued From page 43 take her medications as she's always ready to take them, and wants the cold water from the frig so I didn't have any concerns that she wouldn't take them. ULP-F stated maybe she should have asked her supervisor about that. The licensee's Administration of Medication by Resident Assistant Policy dated August 1, 2021, indicated: 7. The resident assistant will bring the medications to the resident, verify the correct resident will be receiving the medications and observe them swallow the medications. 9. If a resident requests a resident assistant to leave medications for them to take later, staff must explain that they are required to observe them swallow the medications and they are not allowed to leave medications out of the locked medication drawers unless specifically instructed by a nurse to do so. 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 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	01760		

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01760	Continued From page 44 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 clarified and transcribed correctly per physician order for one of three 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: On August 24, 2022, at 8:54 a.m. unlicensed personnel (ULP)-F was observed to administer medications to R4. ULP-F compared order on the medication administration record (MAR) with the label on the container of Citrucel (bulk forming laxative) and placed one teaspoon of Citrucel into a glass of water and stirred it. ULP-F then handed the glass to R4 and observed him drink the mixture. After R4 had consumed the medication, ULP-F signed her initials on the MAR. R4's record included a physician order dated August 10, 2022, for Citrucel one tablespoon 30 milliliters (ml) by mouth daily mix with water. R4's medication administration record (MAR)	01760		

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01760	Continued From page 45 dated August 2022, included: Citrucel dissolve one teaspoon powder in a full glass of water daily by mouth. On August 24, 2022, at 1:26 p.m. clinical administrator (CA)-B verified the physician order should have been clarified from the physician since 30 ml is two tablespoons, and confirmed that had not occurred. CA-B further verified the order had not been transcribed in the MAR as ordered by physician. The licensee's Medication Transcription into R-Tasks policy dated February 2020, included: A second person will verify the accuracy of the medication transcription and any questions on the order will be followed up with medical doctor (MD) ordering and a notation made in the clinical record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	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 observation, interview and record review, the licensee failed to ensure documentation of medication setup included all	01770		

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the required content for one of two residents (R1) 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:

During the entrance conference on August 22, 2022, at 11:00 a.m. registered nurse (RN)-J confirmed the licensee provided medication management services to the licensee's residents, including medication setup.

R1's Service Plan dated August 9, 2022, indicated R1 received weekly medication set-up by the RN.

R1's prescriber orders dated May 11, 2022, included the following orders: aspirin (blood thinner) 325 mg (milligrams) take one tablet by mouth daily, duloxetine (an antidepressant) 30 mg take two capsules by mouth daily, gabapentin (an anticonvulsant utilized for neuropathic pain) 300 mg take two capsules by mouth two time a day, and lisinopril 5 mg take one tablet by mouth daily for high blood pressure.

On August 23, 2022, at 9:35 a.m. unlicensed personnel (ULP)-C was observed setting up R1's AM medication for administration; each medication was set up in it's own blister packaging for the month. When ULP-C was

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setting up R1's aspirin, duloxetine, gabapentin, and lisinopril, the surveyor observed there was no pharmacy label on the blister packaging for each of those medications. R1's name, the name of the medication, dosage, route and time to be taken were hand written on the top of each blister pack. When interviewed at that time ULP-C stated not knowing why the medications didn't have an original pharmacy label, and stated maybe the nurses set those medications up, but wasn't sure. ULP-C confirmed there were no bottles of these medications with original pharmacy labels to compare to that were kept in the resident's locked medication container in the apartment.

R1's Medication Administration Record (MAR) dated August 2022, did not include evidence of medication set-up by the RN in blister packs for the above medications.

On August 23, 2022, at approximately 3:30 p.m. clinical administrator (CA)-B stated she had talked with RN-G who was responsible for setting up R1's aspirin, duloxetine, gabapentin, and lisinopril into the blister packaging. CA-B confirmed that RN-G had not completed documentation for the set-up of the medications. CA-B stated the ULP were not trained to administer medications from bottles. CA-B confirmed when residents had medications in bottles they needed to use up, it was their practice for the RN to set those medications up in blister packaging until the medication needed to be reordered.

The licensee's Medication Management Policy revised July 18, 2022, indicated: 8. c. The preferred method of medication administration is in prepackaged blister cards provided from the

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01770	Continued From page 48 pharmacy. This includes over the counter medications. d. Medications dispensed in a bottle will be set up by the nurse in blister pack for resident assistant administration or Medi-planner for resident self-administration if needed. Nurse set up blister packs will only be used for short-term use (i.e. until dispensed in blister packs by pharmacy) unless VA (Veterans Administration) or 90-day pharmacy mail order supply. Unscheduled nurse visits may apply. e. Medication set-up (oral, liquid, injectable) will occur in a clean well-lit area using appropriate infection control techniques. i. All Medication set ups will be completed by a licensed nurse. ii. Documentation of the medications set up will occur in the medical record and must include date of set up, name of medications, quantity of dose, times to be administered, route of administration, name of person completing medications setup, and description of medications. iii. Medication set-up requires the following information to be added to the new label: Resident name, medications name, medication dose, quantity of dose, times to be administered, route of administration, expiration date, and initials of licensed nurse completing the setup. iv. All original bottles of medication used to set up medications will be stored with the medication as reference (e.g., resident's medication cupboard) until the medication is used up or discontinued and removed for destruction. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will	01790		

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01790	Continued From page 49 (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the	01790		

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01790	Continued From page 50 medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure delegated procedures were followed for one of one resident (R1) who requested medications for an unplanned leave of absence. 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 August 24, 2022, at 9:57 a.m. unlicensed	01790		

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01790	Continued From page 51	01790		

personnel (ULP)-F was observed entering R1's apartment to administer medications to the resident. R1 informed ULP-F she would be visiting a friend that day and would need her 2:00 p.m. and 8:00 p.m. medications packaged to take with her. ULP-F set up R1's medications to administer in a med cup and also set up the requested medications for the resident to take with her in two small envelopes. ULP-F brought R1's medications out to the living room where R1 was sitting and placed them on the table next to her. The envelopes containing R1's 2:00 p.m. and 8:00 p.m. medications were each labeled with the resident's name, time of administration, and date; they did not indicate what medications and dosage were in each envelope.

On August 24, 2022, at 1:35 p.m. clinical administrator (CA)-B confirmed they would expect the ULP when setting up medications for residents when away, to label the envelope with the date the medication is to be taken, resident name, and all medications and dosage that are in the envelope. CA-B stated there is also a form that can be printed out on "Our Tasks" by the nurse that will print out each medication with date and time taken that they can send with the resident and would check with the nurse to see if this had been completed. At 1:47 p.m., CA-B returned to confirm that there was a form available for the ULP to fill out and have the resident sign and this had not been completed per policy.

When interviewed on August 24, 2022, at 2:13 p.m. ULP-F confirmed when setting up R1's 2:00 p.m. and 8:00 p.m. medications she did not label the envelopes with the names and dosage of the meds but did sign them out on the medication administration record (MAR) as "given" with a

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circle around her initials as unknown if the resident actually had consumed them or not.

The licensee's Delegation of Leave of Absence Medications, revised August 26, 2022, indicated:
1. Note: Unlicensed staff can only be delegated this procedure if the resident's absence is not to exceed 120 hours.
2. Contact the RN (in the building or on-call/triage) upon notification by resident or family of plans to be absent during medication administration times to seek directions. (Special instructions may include the need for the RN to talk to the resident or resident's representative, instructions for storage, or for controlled substances.)
a. Fill out the form with the resident name, date, number of pills sent for each medication.
3. Review the MAR (Medication Administration Record) to determine the medications that will need to be sent with the resident.
4. Obtain medications that will be needed for the planned LOA (leave of absence).
5. Obtain the AL (Assisted Living) Medications for LOA Form.
a. Fill out the form with the resident name, date, number of pills sent for each medication.
6. Set up medications:
a. Place meds in med envelope
b. Use a separate envelope for each med pass (one envelope for AM meds, 1 for noon, etc.)
c. On envelope write resident's name, date, what medications are in the envelope, and what time they should be taken.
d. Give medications to resident or resident's family member.
e. On the facility copy of the MAR (where medications are currently signed out), initial and circle meds and on the back page document

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01790	Continued From page 53 "Meds sent with resident or resident's family". 7. Request Signature from resident and/or resident's representative signature to attest receipt of information of Medications for LOA form. 8. Make copy of Medications for LOA form (once signed) and place a copy in the resident's MAR binder. 9. Give one copy of Medications for LOA form (once signed) and place a copy in the resident's MAR binder. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

Minnesota Department Of Health
Food, Pools, & Lodging Services
P.O. Box 64975
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651-201-4500

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Date: *08/22/22*
Time: 11:30:53
Report: 8075221161

Food and Beverage Establishment Inspection Report

Location:
Newton Manor
10000 Newton Avenue South
Bloomington, MN55431
Hennepin County, 27

Establishment Info:
ID #: 0037691
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9529483000
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.

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

Note: The Newton Manor kitchen is not currently in use. Residents receive food from the adjacent kitchen at The Commons.

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 8075221161 of 08/22/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed: Erin Tibbetts
Erin Tibbetts
Public Health Sanitarian
Metro District Office
651-201-3987
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