DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 2, 2022

Administrator
Valleyview Of Northfield
812 Linden Street North
Northfield, MN 55057

RE: Project Number(s) SL30330015

Dear Administrator:

On July 12, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the February 11, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
State Rapid Response Team / State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970 / P.O. Box 3879
St. Paul, MN 55164-0970 / 55101-3879
Telephone: 651-247-0268 Fax: 651-281-9796 / 651-215-9697

PMB

Electronically delivered

May 6, 2022

Administrator
Valleyview Of Northfield
812 Linden Street North
Northfield, MN 55057

RE: Project Number(s) SL30330015

Dear Administrator:

On April 26, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on February 11, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the February 11, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on February 11, 2022, found not corrected at the time of the April 26, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4 = $500.00
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - $500.00
2310-Appropriate Care And Services-144g.91 Subd. 4 = $3,000.00

The details of the violations noted at the time of this follow-up evaluation completed on April 26, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:
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.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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

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

We urge you to review these orders carefully. If you have questions, please contact Jess Gallmeier at 651-247-0268.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 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
	30330	A. BUILDING: _____ B. WING _____	R 04/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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 # SL30330015 On April 25, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 11, 2022. At the time of the survey, there were 41 residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued. On April 26, 2022, the immediacy of correction order 2310 has been removed, however non-compliance remains at a scope and level of G.	{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.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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: No further action required.	{0 480}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	{0 810}		

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{0 810}	Continued From page 2 (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff	{01440}		

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{01440}	Continued From page 3	{01440}		

administering the medication or treatment and the interaction with the resident.
(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure supervision was completed within 30 calendar days of beginning to provide delegated tasks for two of two unlicensed personnel ((ULP)-B, ULP-F) 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:

ULP-B was hired on February 24, 2021, and ULP-F was hired on August 20, 2021.

ULP-B and ULP-F's records included a training checklist both dated March 15, 2022, identified by administrator (A)-C as all training for both ULPs.

The checklist indicated ULP-B and ULP-F were trained in medication administration and

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{01440}	Continued From page 4 treatment management by the registered nurse (RN). A-C indicated medication administration and treatment management were delegated to the ULPs by the RN through training. ULP-B and ULP-F's records lacked documentation of supervision of the delegated tasks due on or before April 14, 2022. On April 25, 2022, at approximately 11:00 a.m., the surveyor observed ULP-B and ULP-F provide the delegated task of medication administration to multiple residents. On April 25, 2022, at approximately 11:30 a.m., A-C stated documentation of supervision within 30 days of the RN delegating tasks to the ULP would not be included in the records. A-C indicated the licensee had not created a supervision document for the delegated task and documentation would not be in any record. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated August 1, 2021, indicated supervision of delegated activities would occur within 30 days and documentation would be included in each employee's record. No further information provided.	{01440}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	{01620}		

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{01620}	Continued From page 5	{01620}		

from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment within the required time frames for two of four residents (R2, R8) 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 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:

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{01620}	Continued From page 6 R2 admitted on October 15, 2019. R2's 90 Day Service Plan dated July 8, 2021, was identified by administrator (A)-C as R2's most recent assessment. R2's assessment was due to be completed on October 6, 2021, and was 201 days overdue to be completed. R8 admitted on November 9, 2021. R8's 14 Day Service Plan dated December 21, 2021, was identified by A-C as R8's most recent assessment. R8's assessment was due to be completed on March 21, 2022, and was 35 days overdue to be completed. On April 25, 2022, at approximately 3:00 p.m., A-C acknowledged R2 and R8's assessment were overdue. A-C stated the RN must have gone back into the old assessments to update them and failed to change the dates to reflect the assessments were completed within the proper time frame. A-C stated the assessment dates do not reflect when the assessments were actually completed but acknowledged the assessments appeared to be overdue based on the record review. The licensee's 6.01 Assessments, Reviews, & Monitoring policy dated August 1, 2021, indicated assessments could not exceed 90 calendar days from the previous assessments and would be documented in the resident's records. No further information provided.	{01620}		
{02310} SS=G	144G.91 Subd. 4 Appropriate care and services	{02310}		

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{02310}	Continued From page 7 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of two residents (R7) who utilized bed rails with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R7 admitted on February 22, 2013. R7's Side Rail Assessment dated March 18, 2022, indicated R7 used side rails for bed positioning and to promote independence. On April 25, 2022, at approximately 1:30 p.m., the surveyor observed bilateral (both sides) bed rails on R7's bed. The bed rail consisted of a single white painted metal pipe in the shape of an upside down elongated, "U," with arms extending between the box frame and mattress. There were two individual but similar styled side rails on both	{02310}		

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{02310}	Continued From page 8	{02310}		

sides of the bed. Each side rail's arm had a non-stick coating on them in an attempt to prevent them from sliding between the box frame and mattress easily. The side rails were not physically attached to the frame of the bed. The surveyor grasped the top of the side rail and was able to easily pull the side rail out completely from between the box frame and mattress.

On April 25, 2022, at approximately 2:00 p.m., administrator (A)-C acknowledged R7's side rails were purchased and installed by R7 but was unable to identify the specific date they were installed. A-C stated a registered nurse (RN) side rail assessment and risk versus benefits education was provided to the resident by RN-A, but no documentation was in R7's record as to if the side rails were secured to the bed appropriately. A-C acknowledged this placed the resident at risk of injury and would need to be corrected to prevent injury.

The licensee's 6.28 Side Rails policy dated August 1, 2021, indicated, when siderails are in use the licensee would ensure, "The side rails are installed securely and maintained in good operating condition."

The Food and Drug Administration's (FDA), A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by

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{02310}	Continued From page 9 the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. Immediacy is removed as confirmed email with evaluation supervisor on April 26, 2022, however noncompliance remains at a scope and severity of G.	{02310}		

Electronically Delivered

March 10, 2022

Administrator
Valleyview Of Northfield
812 Linden Street North
Northfield, MN 55057

RE: Project Number(s) SL30330015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on February 11, 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, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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 addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

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

Sincerely,

Jessica Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30330	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

(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 On February 9, 2022, the immediacy of correction order 2310 has been removed, however non-compliance remains at a scope and level of F. ******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: #SL30330015 On February 7, through February 11, 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 39 residents receiving services under the provider's Assisted Living license. On February 9, 2022, the immediacy of correction order 2310 has been removed, however non-compliance remains at a scope and level of F.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 7, 2022, at approximately 10:00 a.m., administrator (A)-C identified as LALD for facility. A-C obtained an assisted living director license on July 7, 2021. On February 7, 2022, at approximately 10:00 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated A-C held a current assisted living director license. The BELTSS website did not indicate A-C was listed as the Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 On February 7, 2022, at approximately 10:00 a.m., A-C acknowledged they were not listed as the Director of Record for licensee and would contact BELTSS for correction. The licensee lacked a policy or procedure related to the LALD role and responsibility. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days On February 9, 2022, at approximately 10:00 a.m., A-C was listed on the BELTSS website as the Director of Record.	0 110		
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in	0 250		

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0 250	Continued From page 3 any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and	0 250		

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0 250	Continued From page 4 implemented current policies and procedures as required 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 included: On May 7, 2021, the licensee attested comprehension of required statutes related to operation of an assisted living facility. The licensee was issued a forty-two (42) bed Assisted Living Facility license on August 1, 2021. On February 7, 2022, during the entrance conference at approximately 10:00 a.m., administrator (A)-C attested to comprehension of assisted living laws and regulations. A-C indicated they are in charge of day-to-day operations for the licensee. On February 11, 2022, at the time of exit, the licensee was issued thirty-two (32) citations for failure to perform in the following areas as documented on this form in its entirety: - Required posted information - Infection control - Quality management - Abuse prevention planning - Disaster Planning - Contract requirements - Documentation of training and orientation - Supervision of staff	0 250		

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0 250	Continued From page 5 - Assessments of residents - Service plan requirements - Medication management requirements - Treatment management requirements - Safety of residents As a result of this survey, the following orders were issued [0110, 0250, 0430, 0450, 0470, 0480, 0510, 0550, 0580, 0630, 0680, 0810, 0900, 0950, 0970, 1370, 1380, 1440, 1480, 1530, 1610, 1620, 1640, 1650, 1670, 1710, 1730, 1790, 1940, 2310, 2410, and 3090], indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted	0 430		

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0 430	Continued From page 6 living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On February 7, 2022, at approximately 10:00 a.m., administrator (A)-C provided the surveyor a copy of the licensee's completed UDALSA dated May 17, 2021. R1 admitted September 21, 2021. R1's Acknowledgement Signature Document, dated September 21, 2021, indicated R1 received licensee's Statement of Home Care Services. R1's record lacked documentation of receipt of the licensee's UDALSA. R2 admitted October 15, 2019.	0 430		

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0 430	Continued From page 7 R2's Acknowledgement Signature Document, dated October 16, 2019, indicated R2 received licensee's Statement of Home Care Services. R2's record lacked documentation of receipt of the licensee's UDALSA. R3 admitted August 22, 2019. R3's Acknowledgement Signature Document, dated August 23, 2019, indicated R3 received licensee's Statement of Home Care Services. R3's record lacked documentation of receipt of the licensee's UDALSA. On February 9, 2022, at approximately 10:00 a.m., A-C acknowledged no documentation of receipt of licensee's UDALSA would be included in the residents' records. A-C stated the licensee had provided a Home Care Statement of Services to the residents upon admission. The licensee lacked a policy regarding the UDALSA. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process;	0 450		

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0 450	Continued From page 8 (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current assisted living bill of rights (BOR) to three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On February 7, 2022, at approximately 10:00 a.m., administrator (A)-C provided undated Health Care Bill of Rights of Supervised Living Facilities. The document referenced Minnesota Statutes 144.651 (sic) related to home care, not Minnesota Statutes 144G for assisted living (under which the licensee operated). R1 admitted September 21, 2021. R1's Acknowledgement Signature Document, dated September 21, 2021, indicated R1 received the Minnesota home care BOR. R1's record lacked documentation of receipt of the current	0 450		

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0 450	Continued From page 9 assisted living BOR, dated May 16, 2021. R2 admitted October 15, 2019. R2's Acknowledgement Signature Document, dated October 16, 2019, indicated R2 received the Minnesota home care BOR. R2's record lacked documentation of receipt of the current assisted living BOR, dated May 16, 2021. R3 admitted August 22, 2019. R3's Acknowledgement Signature Document, dated August 22, 2019, indicated R3 received the Minnesota home care BOR. R3's record lacked documentation of receipt of the current assisted living BOR, dated May 16, 2021. On February 9, 2022, at approximately 10:00 a.m., A-C acknowledged the BOR provided and documented as received in the residents' record was not the current assisted living BOR. A-C indicated the licensee had created their own BOR based on the home care BOR, not the assisted living BOR and provided to all residents. A-C stated the licensee would need to provide and document receipt of current assisted living BOR to all residents. The licensee's 1.03 Bill of Rights policy, dated December 29, 2014, lacked identification to provide the current assisted living BOR to residents. The policy referenced the home care BOR. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		

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0 470	Continued From page 10	0 470		
0 470 SS=C	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 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 as required, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a	0 470		

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0 470	Continued From page 11 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On February 7, 2022, at approximately 11:00 a.m., the surveyor did not observe a posted staff schedule during a tour of the facility. The licensee lacked a posted daily staffing schedule after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. On February 7, 2022, at approximately 11:00 a.m., administrator (A)-C acknowledged the licensee was not aware a staffing schedule had to be posted for residents, staff, and visitors to be able to access in common area. The licensee lacked a policy for a posted staff schedule. 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 12 (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 February 11, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 13 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards related to COVID-19. 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 February 8, 2022, the surveyor observed unlicensed personnel (ULP)-B and ULP-D provide medication administration, blood glucose checks, and activities of daily living services to residents when no eye protection was in place as recommended by the Center for Disease Control (CDC) for nursing standards.	0 510		

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0 510	Continued From page 14 On February 9, 2022, at approximately 10:00 a.m., administrator (A)-C acknowledged ULPs were not wearing eye protection as recommended and stated the ULPs should wear eye protection when in close contact or providing care to residents. A-C stated the expectation is to wear googles or a face shield when services are provided. The licensee's 7.10 Coronavirus COVID-19 policy, dated August 26, 2020, indicated eye protection is to be worn by employees. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the Office of Ombudsman for Mental Health and Developmental Disabilities'	0 550		

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0 550	Continued From page 15 contact information was posted as required, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On February 7, 2022, at approximately 11:00 a.m. during a tour of the facility, the surveyor did not observe the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities in any area of the facility. On February 7, 2022, at approximately 11:00 a.m., administrator (A)-C acknowledged the licensee was not aware the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities had to be posted in a conspicuous placed for residents, staff, and visitors to access. The licensee lacked a policy for the required posted information. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 580	Continued From page 16	0 580		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On February 7, 2021, at approximately 10:00 a.m., during the entrance conference, administrator (A)-C stated a QMP had not	0 580		

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0 580	Continued From page 17 officially been developed or implemented. A-C stated the licensee provided ongoing improvement as areas were identified, but no meeting minutes, tracking, or specific improvement projects would be documented. The licensee's 1.26 Quality Improvement Project policy, dated December 29, 2014, indicated a QMP would be implemented, and documentation would be provided upon request. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) to include an assessment of a resident's susceptibility to abuse by another resident; a	0 630		

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0 630	Continued From page 18 resident's risk to abuse another resident; and interventions of the specific measures to be taken to minimize the risk of abuse, for three of three residents (R1, R2, and R3) 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 the residents). The findings include: R1 On February 8, 2022, at approximately 8:00 a.m., unlicensed personnel (ULP)-B provided R1 medication management and activities of daily living services. R1 admitted September 21, 2021, with diagnosis of atrial fibrillation, congestive heart failure, major depressive disorder, anxiety, and diabetes type 2. R1's undated and unsigned Pre-Admit Service Plan did not indicate R1 received any services. R1's record included a blank Client Vulnerability Assessment form dated September 20, 2021, identified by administrator (A)-C as R1's IAPP. The form listed multiple areas of vulnerability on the left side to be assessed by a registered nurse (RN), but the right side of the form was blank and indicated at the bottom R1 had no areas of vulnerability. R1's record lacked a developed and implemented IAPP as required.	0 630		

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0 630	Continued From page 19 R2 On February 8, 2022, at approximately 7:00 a.m., ULP-B provides R2 medication management and activities of daily living services. R2 admitted October 15, 2019, with diagnosis of schizoaffective disorder, post-traumatic stress disorder, alcohol-induced psychotic disorder, major depressive disorder, and ventricular tachycardia. R2's 90 Day Service Plan, dated July 8, 2021, did not indicate R2 received any services. R2's record included a blank Client Vulnerability Assessment form, dated September 20, 2021, identified by a A-C as R2's IAPP. The form listed multiple areas of vulnerability on the left side to be assessed by a RN, but right side of the form was blank and indicated at the bottom R2 had no areas of vulnerability. R3 On February 8, 2022, at approximately 8:00 a.m., observed ULP-B provided R3 medication management services. R3 admitted August 22, 2019, with diagnosis of hypertension, diabetes type 2, anxiety disorder, depression, schizophrenia, and agoraphobia with panic disorder. R3's undated and unsigned 90 Day Service Plan did not indicate R3 received any services. R3's record included a blank Client Vulnerability Assessment form, dated September 20, 2021, identified by A-C as R3's IAPP. The form listed multiple areas of vulnerability on the left side to	0 630		

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0 630	Continued From page 20 be assessed by a RN, but the right side of the form was blank and indicated at the bottom R3 had no areas of vulnerability. On February 9, 2022, at approximately 10:00 a.m., A-C acknowledged the IAPPs for R1, R2, and R3 were blank. A-C stated the IAPP forms should have been completed and identified the vulnerabilities and specific intervention the licensee should take to minimize the risk of abuse for each resident. A-C indicated the licensee's expectation is all residents would have a completed and implemented IAPP. The licensee's 1.24 Maltreatment - Communication, Prevention, and Reporting policy, dated August 1, 2021, indicated an IAPP would be developed for each resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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;	0 680		

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0 680	Continued From page 21 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to impact all residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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 February 7, 2022, at approximately 11:00 a.m. during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's emergency preparedness plan posted	0 680		

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0 680	Continued From page 22 in a prominent location. The licensee's emergency binder contained names of executive officers, an organizational chart, facility diagram, and multiple policy and procedures related to fire, flood, and shelter in place. The licensee's plan lacked the following required content: -current, all-hazards approach facility assessment; -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of policies/procedures, based on assessment; and additional policies for: -potential evacuation; -handling medical documents; -handling and use of volunteers; -arrangement with other faculties (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On February 7, 2022, at approximately 11:00 a.m., administrator (A)-C acknowledged the emergency preparedness plan was not posted in a common area. A-C provided the emergency preparedness binder for the surveyor to review.	0 680		

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0 680	Continued From page 23 On February 9, 2022, at approximately 10:00 a.m., A-C acknowledged the licensee's emergency preparedness plan lacked the required content and was not posted in a prominent area. A-C stated the plan would need to be expanded and required policy and procedures would need to be developed to be included in the plan. The licensee's 7.01 Disaster Planning and Emergency Preparedness Plan policy, dated December 29, 2014, lacked identification of all required content for an assisted living facility emergency preparedness plan. The policy referenced comprehensive home care requirements, not assisted living statutes the licensee operated under. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	0 810		

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0 810	Continued From page 24 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed provide required employee training on fire safety and evacuation; failed to provide training to residents who are capable of self-evacuation in the event of a fire; and failed to conduct evacuation drills for employees every other month. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 25 Findings include: A record review and interview were conducted on February 10, 2022, between approximately 10:00 a.m. and 10:50 a.m. with the Administrator (A)-C. on the fire safety and evacuation plan, training, and evacuation drills for the facility. Record review indicated that employees did not receive training twice per year after initial hire on the facility fire safety and evacuation plan. During interview, (A)-C stated that the licensee provides training to employees at initial hire and annually thereafter. Record review indicated that licensee did not provide training on the proper actions to take in the event of a fire including movement, evacuation, or relocation at least once a year to residents who are capable of assisting in their own evacuation. During interview, (A)-C stated that the licensee does provide training to residents on fire safety but had nothing documented or in policy to verify that this training occurred at least once per year. Record review indicated that that the licensee did not have documentation indicating that evacuation drills had been conducted every other month as required. During interview, (A)-C stated that the licensee had not conducted any evacuation drills to date and that they were working on a policy for evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 900	Continued From page 26	0 900		
0 900 SS=E	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. (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.	0 900		

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0 900	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for two of three residents (R2 and R3) 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 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 began operations under their assisted living facility license on August 1, 2021. On February 7, 2022, administrator (A)-C provided a blank assisted living lease contract and indicated the contract is used by the licensee for all residents who received services by licensee. R2 admitted October 15, 2019. R2's record included a scanned Housing with Services Lease/Contract dated October 16, 2019. Additionally, R2's Acknowledgement Signature Document, dated October 16, 2019, indicated R2 received a housing with services contract. R2's record lacked an assisted living contract with required content.	0 900		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 900	Continued From page 28 R3 admitted August 22, 2019. R3's record included a scanned Housing with Services Lease/Contract dated August 22, 2019. Additionally, R3's Acknowledgement Signature Document, dated August 23, 2019, indicated R3 received a housing with services contract. R3's record lacked an assisted living contract with required content. On February 7, 2022, at approximately 10:00 a.m., A-C acknowledged the licensee's assisted living contract was not included in R2 and R3's record. A-C stated the licensee would need to provide the new assisted living contract to the residents with the old Housing With Services Lease/Contract. The licensee lacked a policy related to assisted living contracts. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your	0 950		

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0 950	Continued From page 29 "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representatives verbatim statutory language notice for one of one resident (R1) 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) 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:	0 950		

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0 950	Continued From page 30 On February 7, 2022, administrator (A)-C provided a blank assisted living lease contract and indicated the contract is used by the licensee for all residents who received services by licensee. The assisted living lease contract lacked the verbatim right to designate a representative for certain purposes notice required at the time of execution of the contract. R1's record included a scan of the signature page for an Assisted Living Lease Contract dated August 21, 2021. R1's assisted living contract with the required verbatim notice for the designation of representative. On February 9, 2022, at approximately 10:00 a.m., A-C acknowledged the required verbatim notice was not included in the licensee's assisted living contract. A-C stated the licensee was not aware of the verbatim language required per statute. The licensee lacked a policy related to an assisted living contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=F	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	0 970		

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0 970	Continued From page 31 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 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 February 7, 2022, administrator (A)-C provided a blank Assisted Living Lease Contract and indicated the contract is used by the licensee for all residents who received services. The contract included a liability waiver page separate from the contract but included with the contract. R1's record included a scan of the signature page for R1's Assisted Living Lease Contract dated September 21, 2021. R1's record included a scan of the Release, Waiver, Assumption of the Risk, and Indemnity Agreement form, dated September 21, 2021, indicating R1 waived their liability for safety and well-being.	0 970		

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0 970	Continued From page 32 On February 9, 2022, at approximately 10:00 a.m., A-C acknowledged the liability waiver was provided to all residents by the licensee. A-C stated the licensee was not aware of the prohibition of liability waiver in statutory language. A-C stated the waiver would be removed from all resident's records. The licensee lacked a policy related to the devolvement and contents of an assisted living contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01370 SS=F	144G.61 Subd. 2 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;	01370		

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01370	Continued From page 33 (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; (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 interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel ((ULP)-B) to include all required content 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), 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:	01370		

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01370	Continued From page 34 ULP-B was hired on February 24, 2021. ULP-B's record lacked documentation of completed training and competency for the following: - hygiene and grooming - standby assistance - basic nutrition - preparation of modified diets - commonly used assistive devices. On February 8, 2022, at approximately 7:00 a.m., ULP-B stated they were not trained in the above identified areas prior to providing services to residents. ULP-B stated they had been working in the same role for nearly one year and provided cares to residents during that time. On February 9, 2022, at approximately 10:00 a.m., administrator (A)-C acknowledged ULP-B's record lacked documentation of the required training. A-C stated the licensee recently had reviewed the required training topics and were in the process of developing a program for the topics, the missing training would not have been provided to any ULPs already working for licensee. The licensee's 3.04 Training and Competency Evaluations and Unlicensed Personnel policy, dated December 29, 2014, indicated all required training and documentation for all training would be kept in each employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01380	Continued From page 35	01380		
01380 SS=F	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel ((ULP)-B) to include all required content 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), 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:	01380		

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01380	Continued From page 36 ULP-B was hired on February 24, 2022. ULP-B's employee record lacked documentation of completed training and competency for the following: - observation, reporting, and documenting status - basic body knowledge - recognizing needs - safe transfers - range of motion On February 8, 2022, at approximately 7:00 a.m., ULP-B stated they were not trained in the above identified areas prior to providing services to residents. ULP-B stated they had been working in the same role for nearly one year and provided cares to residents during that time. On February 9, 2022, at approximately 10:00 a.m., administrator (A)-C acknowledged ULP-B's record lacked documentation of the required training. A-C stated the licensee recently had reviewed the required training topics and were in the process of developing a program for the topics, the missing training would not have been provided to any ULPs already working for licensee. The licensee's 3.04 Training and Competency Evaluations and Unlicensed Personnel policy, dated December 29, 2014, indicated all required training and documentation for all training would be kept in each employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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01440	Continued From page 37	01440		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure supervision was completed within 30 calendar days of beginning to provide delegated tasks for one of one unlicensed personnel ((ULP)-B) 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	01440		

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01440	Continued From page 38	01440		

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 February 8, 2022, at approximately 7:00 a.m., ULP-B provided the delegated task of blood glucose check to R1 and R3.

ULP-B was hired on February 24, 2021.

ULP-B's HHA Final Test Out form, dated March 9, 2021, indicated registered nurse (RN)-A provided training and delegated blood glucose checks to ULP-B. ULP-B's employee record lacked documentation of direct supervision by the RN within 30 calendar days from March 9, 2021, when blood glucose checks were delegated.

On February 9, 2022, at approximately 10:00 a.m., administrator (A)-C acknowledged ULP-B's record lacked documentation of supervision for a delegated task within 30 days. A-C stated that RN-A does check in with ULPs to ensure delegated tasks are performed correctly, but no documentation of the supervision and checks would be in any ULP's records.

The licensee's 3.05 Delegated Nursing Services policy, dated December 28, 2014, lacked RN supervision would be completed within 30 calendar days from the day the task was first delegated and would be documented in the employee's record.

No further information provided.

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01440	Continued From page 39 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for one of one employee (unlicensed personnel (ULP)-B) 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 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 February 8, 2022, at approximately 7:00 a.m., ULP-B provided medication management, blood glucose checks, and activities of daily living to residents. ULP-B hired on February 24, 2021. ULP-B's	01480		

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01480	Continued From page 40 record lacked documentation of orientation to each resident and services to be provided. On February 8, 2022, at approximately 7:00 a.m., ULP-B stated they shadowed other employees to learn about the residents and how to provide services to the residents based on the residents' preferences. On February 9, 2022, at approximately 10:00 a.m., administrator (A)-C acknowledged no documentation of orientation to each resident would be in any ULP's records. A-C stated licensee did not have a system in place to document the orientation, but each ULP is required to spend time with the registered nurse and other ULPs to learn about each resident's services and needs prior to providing any services. The licensee's 3.01 Orientation for Home Care Staff policy, dated December 29, 2014, indicated staff would be orientated specifically to each client (sic). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01480		
01530 SS=D	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	01530		

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01530	Continued From page 41 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 employees received the required hours of dementia care training for one of two employees (registered nurse (RN)-A) with training 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:	01530		

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01530	Continued From page 42 RN-A hired February 10, 2010. RN-A's My Transcript, dated February 7, 2022, was identified by RN-A and administrator (A)-C as RN-A's complete training record. RN-A's My Transcript indicated RN-A completed four and a half (4.5) hours of dementia training on February 13, 2020, and no further dementia training thereafter. On February 9, 2022, at approximately 10:00 a.m., A-C acknowledged RN-A's initial dementia training and annual dementia training was not completed as required. A-C stated the trainings are assigned by licensee, but the licensee failed to assign the required initial and annual dementia trainings to be completed by RN-A. The licensee's 3.02 Alzheimer's Disease and Related Disorders - Training and Notification policy, dated December 29, 2014, lacked identification of required training hours and time frames training to be completed within. No further information provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01530		
01610 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident	01610		

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01610	Continued From page 43	01610		

executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of one resident (R1) 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:

R1 admitted on September 21, 2021, with diagnoses of atrial fibrillation, congestive heart failure, major depressive disorder, anxiety, and diabetes type 2.

R1's record included unsigned Baseline Assessment and a Detailed Admission Assessment Assessment (sic) both created September 20, 2021. Additionally, R1's record included undated and unsigned Pre-Admit

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01610	Continued From page 44 Service Plan. The three documents were arranged by licensee's electronic health record with each area to be assessed or reviewed in the left column, with the RN assessment to be documented in the right column with the ability of the RN to add comments to each area as needed. R1's Detailed Admission Assessment Assessment (sic) lacked any documentation of an RN assessment and all areas in right column were blank. R1's Baseline Assessment identified R1's diagnoses, assistive devices required, and allergies. The areas assessed marked, "No," included diabetes, heart disease, mobility issues, mental illness, and alert contrary to R1's diagnosis list. The assessment lacked evidence of a completed RN assessment as most areas were marked, "No," and failed to be fully completed. R1's Assessment lacked identification and authentication of who and what discipline created and completed the document. On February 9, 2022, at approximately 10:00 a.m., administrator (A)-C acknowledged R1's assessments were not completed in a manner that reflected R1's status and needs. A-C stated the licensee is unsure why the assessments were not completed with the accurate information and the expectation is RN would complete assessments fully. The licensee's 4.03 Assessment - Schedules policy, dated December 29, 2014, lacked identification of the assisted living assessment time frames and content. The policy referenced Minnesota Statutes 144A related to home care, not assisted living. No further information provided.	01610		

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01610	Continued From page 45 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=F	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool and within the required	01620		

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01620	Continued From page 46 time frames for three of three residents (R1, R2, and R3) 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 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R2, and R3's records lacked 14-day assessments, ongoing 90-day assessments, and required Uniform Assessment Tool content. The assessments lacked to address the follow required content identified on the Uniform Assessment Tool for R1, R2, and R3: - Personal lifestyle preferences - Activities of daily living (ADLs) - Instrumental ADLs - Physical health status - Mental health conditions - Cognition - Treatments - Risk indicators - Decision making authority - Follow up referrals R1 R1 admitted on September 21, 2021. R1's record included Baseline Assessment, created September 20, 2021, identified by RN-A as R1's most recent assessment. The assessment lacked documentation of a RN assessment as, "No," was indicated in areas R1	01620		

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01620	Continued From page 47 would need to be assessed. R1's unsigned and undated Pre-Admit Service Plan indicated no areas were assessed by the RN as the form was blank. R1's record lacked a reassessment within 14 days of initiation of services due by October 5, 2021. R1's record lacked an assessment within 90 calendar days of the previous assessment due on or before January 3, 2022, had R1's 14-day assessment been completed as indicated with required Uniform Assessment Tool content. R2 R2 admitted on October 15, 2019. R2's record included 90 Day Service Plan dated July 8, 2021. R2's record lacked 90-day assessments due on or before October 6, 2021, and January 4, 2022 with required Uniform Assessment Tool content. R3 R3 admitted on August 22, 2019. R3's record included an unsigned and undated 90 Day Service Plan. R3's record included Baseline Assessment, created September 20, 2021, identified by RN-A as R3's most recent assessment. The assessment lacked documentation of a RN assessment as, "No," was indicated in areas R3 would need to be assessed. R3's record lacked a 90-day assessment due on	01620		

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01620	Continued From page 48 or before December 19, 2021, with required Uniform Assessment Tool content. On February 9, 2022, at approximately 10:00 a.m., administrator (A)-C acknowledged R1, R2, and R3's assessments were overdue and lacked the required content from the Uniform Assessment Tool. A-C acknowledged the assessments appeared to have not been completed and do not represent the residents' needs and services provided. A-C stated assessments are behind and are expected to be completed in the required time frames. The licensee's 4.03 Assessment - Schedules policy, dated December 29, 2014, lacked identification of the assisted living assessment time frames and content. The policy referenced Minnesota Statutes 144A related to home care, not assisted living. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=F	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	01640		

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01640	Continued From page 49 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 the current service plan included a signature or other authentication by the resident and the licensee to document agreement on the services to be provided for three of three residents (R1, R2, and R3) 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 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted on September 21, 2021. R1's record included an unsigned and undated Pre-Admit Service Plan.	01640		

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01640	Continued From page 50 R2 R2 admitted on October 15, 2019. R2's record included 90 Day Service Plan, dated July 8, 2021, and authenticated by registered nurse (RN)-A only. R3 R3 admitted on August 22, 2019. R3's record included an unsigned and undated 90 Day Service Plan. On February 9, 2022, at approximately 10:00 a.m., administrator (A)-C acknowledged R1, R2, and R3's service plans lacked a signature or authentication by both the resident and the licensee. A-C stated the licensee had not obtained signatures for any service plans for any resident. A-C stated a process to obtained authentication would need to be implemented by the licensee. The licensee's 4.09 Service Plans policy, dated December 29, 2014, indicated a signature or authentication would be obtained and stored in the record. The policy referred to clients and home care providers, not assisted living as the licensee operates under. No further information provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided,	01650		

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01650	Continued From page 51 the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included all required content for three of three residents (R1, R2, and R3) 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	01650		

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01650	Continued From page 52 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted on September 21, 2021. R1's unsigned and undated Pre-Admit Service Plan lacked all required content as the document was blank. R2 R2 admitted on October 15, 2019. R2's 90 Day Service Plan, dated July 8, 2021, lacked all required content. R3 R3 admitted August 22, 2019. R3's unsigned and undated 90 Day Service Plan lacked all required content. On February 9, 2022, at approximately 10:00 a.m., A-C acknowledged R1, R2, and R3's service plans lacked the required content. A-C stated the licensee used the service plans created by the electronic health record but acknowledged the plans were not completed by the RN as expected. The licensee's 4.09 Service Plans policy, dated December 29, 2014, indicated the required content would be included. The policy referred to clients and home care providers, not assisted living as the licensee operates under. No further information provided. TIME PERIOD FOR CORRECTION:	01650		

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01650	Continued From page 53 Twenty-One (21) days	01650		
01670 SS=C	144G.70 Subd. 6 Medical cannabis Assisted living facilities may exercise the authority and are subject to the protections in section 152.34. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to adopt reasonable restrictions for the use of medical cannabis (commonly referred to as medical marijuana) potentially affecting all current residents in the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 7, 2022, at approximately 10:00 a.m., administrator (A)-C provided the licensee's 2801 Acquisition, LLC, dba Valleyview of Northfield Resident Handbook. The handbook indicated under the Illegal Drugs and Substances section, "Medical Marijuana," had a "zero tolerance" use policy. The handbook indicated any resident found to be using or storing medical marijuana could have their rental agreement immediately terminated. On February 9, 2022, at approximately 10:00	01670		

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01670	Continued From page 54 a.m., A-C acknowledged the handbook indicated residents' rental contracts could be terminated for storing or using medical marijuana. A-C stated the licensee was not aware of the statute and stated the language would be removed as the licensee is in support of medical marijuana. The licensee lacked a policy related to medical cannabis. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01670		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication re-assessments for two of two residents (R2 and R3) 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	01710		

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01710	Continued From page 55 or has the potential to affect a large portion or all of the residents). The findings include: R2 and R3's record lacked an annual reassessment of the medication management services. R2 On February 8, 2022, at approximately 8:00 a.m., unlicensed personnel (ULP)-B provided medication management services to R2. R2 admitted on October 15, 2019. R2's 90 Day Service Plan, dated July 8, 2021, failed to indicate R2 received medication management services. R2's unsigned Medication Management Assessment, created September 20, 2021, indicated R2 did not receive medication management services. The assessment appeared to be blank as assessment areas lacked documentation and Services Needed Based on Assessment section all marked, "No," related to medication management services. R3 On February 8, 2022, at approximately 8:00 a.m., ULP-B provided medication management services to R3. R3 admitted on August 22, 2019. R3's unsigned and undated 90 Day Service Plan indicated R3 received medication management services.	01710		

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01710	Continued From page 56 R3's unsigned Medication Management Assessment, created September 20, 2021, failed to indicate medications management services provided by licensee. The assessment appeared to be blank as assessment areas lacked documentation and Services Needed Based on Assessment section all marked, "No," related to medication management services. On February 9, 2022, at approximately 10:00 a.m., administrator (A)-C acknowledged R2 and R3 received medication management services. A-C unsure why Medication Management Assessments were not completed with required documentation. A-C stated all residents received medication management services while under the care of the licensee. The licensee's 4.03 Assessment - Schedules policy, dated December 29, 2014, indicated an annual medication management assessment would be completed by a RN. The policy referenced Minnesota Statutes 144A related to home care, not assisted living. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01710		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management	01730		

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01730	Continued From page 57 services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01730		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 58	01730		

review, the licensee failed to develop an individualized medication management plan with the required content for three of three residents (R1, R2 and R3) 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 failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R1, R2, and R3's record lacked a completed medication management record.

On February 7, 2022, at approximately 10:00 a.m., administrator (A)-C and registered nurse (RN)-A indicated all residents under licensee's care are provided medication management services as a requirement to reside in the facility.

R1
R1 admitted on September 21, 2021.

R1's unsigned and undated Pre-Admit Service Plan lacked identification R1 received medication management.

R1's unsigned Medication Management Assessment, created September 20, 2021, indicated by A-C as incomplete and lacked all required documentation by the RN.

R2
R2 admitted on October 15, 2019.

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01730	Continued From page 59 R2's 90 Day Service Plan dated July 8, 2021, lacked identification R2 received medication management. R2's unsigned Medication Management Assessment, created September 20, 2021, indicated by A-C as incomplete and lacked all required documentation by the RN. R3 R3 admitted on August 22, 2019. R3's unsigned and undated 90 Day Service Plan lacked identification R3 received medication management. R3's unsigned Medication Management Assessment, created September 20, 2021, indicated by A-C as incomplete and lacked all required documentation by the RN. On February 9, 2022, at approximately 10:00 a.m., A-C acknowledged R1, R2, and R3's records lacked a completed medication management plan and Medication Management Assessments were all considered blank. A-C indicated the expectation is all residents would have a completed medication management plan by the RN and would include all required content. The licensee lacked a policy specifically to a medication management record but did provide a combination of policies all dated December 29, 2014, indicated the required content would be included. The policies referenced, "Comprehensive home care regulations," not assisted living as the licensee operated under. No further information provided.	01730		

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01730	Continued From page 60 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be	01790		

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01790	Continued From page 61 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 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 the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) who provided medications to residents for unplanned time away from home when the licensed nurse was not available for one of one employee (ULP-B) 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	01790		

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01790	Continued From page 62 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 February 8, 2022, ULP-B provided medication management services to R1, R2, and R3. ULP-B was hired on February 24, 2021. ULP-B's record lacked documentation of training and competency for unplanned time away when the RN is not available. On February 9, 2022, at approximately 10:00 a.m., administrator (A)-C acknowledged ULP-B's record lacked documentation of training and competency for unplanned times away. A-C stated ULPs contact the RN for direction when residents had unplanned time away. A-C stated documentation of competency for residents unplanned time away would not be in any employee records. The licensee's 5.12 Medication Administration - Outings and Unplanned Leaves of Absence policy, dated December 28, 2014, indicated the required training and competency for ULPs related to unplanned time away would be provided. The policy referenced, "Comprehensive home care regulations," not assisted living as the licensee operated under. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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01940	Continued From page 63	01940		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management	01940		

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01940	Continued From page 64 plan to include all required content for two of two residents with treatments (R1 and R3) 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: On February 8, 2022, at approximately 7:00 a.m., unlicensed personnel (ULP)-B provided blood glucose checks to R1 and R3. R1 R1 admitted on September 21, 2021, with diagnoses including type 2 diabetes mellitus, major depressive disorder, morbid obesity, and congestive heart failure. R1's unsigned and undated Pre-Admit Service Plan lacked identification R1 received treatment management services. R1's Detailed Order, dated February 8, 2022, indicated R1 had Tresiba (long acting) insulin order with blood glucose treatment prior to administration. Registered nurse (RN)-A indicated ULPs provide blood glucose treatment prior to any insulin administration. R3 R3 admitted on August 22, 2019, with diagnoses including type 2 diabetes mellitus, schizoaffective disorder, and post-traumatic stress disorder.	01940		

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01940	Continued From page 65 R3's unsigned and undated 90 Day Service Plan lacked identification R3 received treatment management services. R3's Detailed Order, dated February 8, 2022, indicated R1 had Lantus (long acting) insulin order with blood glucose treatment prior to administration and Novolog (short acting) insulin order with sliding scale administration (dosing is based on blood glucose result). RN-A indicated ULPs provide blood glucose treatment prior to any insulin administration. On February 9, 2022, at approximately 10:00 a.m., administrator (A)-C acknowledged R1's and R3's records lacked a treatment management plan. A-C indicated the licensee was not aware of required content for a treatment management plan. A-C stated the licensee would need to create treatment management plans for all residents with provider ordered treatments. The licensee lacked a policy specific to treatment management plans but did provide a combination of policies, all dated December 29, 2014, indicated the required content would be included. The policies referenced, "Comprehensive home care regulations," not assisted living as the licensee operated under. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 66 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R5) who utilized bed rails with record reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 8, 2022, at approximately 7:00 a.m., unlicensed personnel (ULP)-B provided R5 ' s morning medications. R5's bed had a siderail on the left side, which was an upside down, "U," shape with adjustable extended feet positioned on the floor. The siderail had a perpendicular extension that proceeded into the bed between the mattress and box spring. An adjustable strap connected the siderail to the bed and looped around the box spring to secure the siderail to the bed. The surveyor grasped the siderail and noted the siderail to be secured to the bed and did not move when pulled and pushed on with force. The surveyor did not observe a gap between the	02310		

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02310	Continued From page 67 siderail and R5's mattress. R5 was admitted to the licensee on August 13, 2009. R2's diagnoses included osteoarthrosis, schizoaffective disorder, osteopenia, and diabetes type 2. R5's Baseline Assessment, dated September 20, 2021, completed by registered nurse (RN)-A, indicated R5 used no assistive devices for mobility or transfers. R5's service plan, dated July 7, 2021, indicated R5 received services including medication management, and activities of daily living. R5 ' s medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of siderails. On February 8, 2022, at approximately 2:00 p.m., RN-A acknowledged R5's siderail were installed by physical therapy but unable to identify the specific date they were installed. RN-A stated it was over a year ago and she could search records for specific date and order for siderail placement. RN-A indicated she had not completed a side rail assessment or had a conversation with R5 or R5 ' s representative about the risks or benefits of side rail use. The licensee's 4.19 Side Rails policy, dated December 29, 2014, indicated, when siderails are in use, the RN shall conduct an assessment to identify the intended purpose of the siderail and the risks regarding the use of the siderail. The policy also stated the client and, when appropriate, the client's representative, shall be informed of the risks and benefits regarding the use of siderails. Such education shall be	02310		

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02310	Continued From page 68 documented in the client record. The Food and Drug Administration's (FDA), A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days Immediacy is removed as confirmed by surveyor's on-site observation on February 9, 2022 and review by evaluation supervisor on February 9, 2022, however noncompliance remains at a scope and severity of F.	02310		
02410 SS=F	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	02410		

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02410	Continued From page 69	02410		

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 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 interview and record review, the licensee failed to provide residents the right to consideration of their privacy and personal property for three of three residents (R1, R2 and R3) 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:

R1 admitted on September 21, 2021, with diagnoses including type 2 diabetes mellitus, major depressive disorder, morbid obesity, and

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02410	Continued From page 70 congestive heart failure. R1's Rules & Regulations of Valleyview of Northfield, dated September 21, 2021, indicated person and room searches would be conducted for suspicion of alcohol, medications, sharps, or illegal substances present and possible eviction if discovered. R1's Acknowledgement Signature Document, dated September 21, 2021, indicated R1 received the Minnesota Home Care Bill of Rights. R2 admitted on October 15, 2019, with diagnoses including schizoaffective disorder, post-traumatic stress disorder, and major depressive disorder. R2's Rules & Regulations of Valleyview of Northfield, dated October 16, 2019, indicated person and room searches would be conducted for suspicion of alcohol, medications, sharps, or illegal substances present and possible eviction if discovered. R2's Acknowledgement Signature Document, dated October 16, 2019, indicated R2 received the Minnesota Home Care Bill of Rights. R3 admitted on August 22, 2019, with diagnoses including type 2 diabetes mellitus, schizoaffective disorder, and post-traumatic stress disorder. R3's Rules & Regulations of Valleyview of Northfield, dated August 23, 2019, indicated person and room searches would be conducted for suspicion of alcohol, medications, sharps, or illegal substances present and possible eviction if discovered. R3's Acknowledgement Signature Document,	02410		

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02410	Continued From page 71 dated August 23, 2019, indicated R3 received the Minnesota Home Care Bill of Rights. On February 9, 2022, at approximately 10:00 a.m., administrator (A)-C acknowledged the licensee would conduct the searches for the safety of the residents. A-C stated this was licensee's practice but had not completed searches on R1, R2, or R3 as they had not been suspected of violations. A-C indicated the rules and regulations were required to be signed by all residents at the time of move in. A-C acknowledged the licensee used an outdated Bill of Rights and did not provide current assisted living bill of rights as indicated in citation 0450 from this survey. The licensee's Health Care Bill of Rights for Residents of Supervised Living Facilities, (as adapted for SLF's from Minnesota Statutes 144.651 Health Care Bill of Rights), undated, indicated, residents shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Facility staff shall respect the privacy of a resident's room by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable. The licensee's 1.03 Bill of Rights policy, dated December 29, 2014, indicated staff would be trained on concepts and rights in the bill of rights. The policy referenced home care and not the current assisted living bill of rights the licensee operated under. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	02410		

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	30330	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

(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 72 days	02410		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 7, 2022, at approximately 11:00 a.m., during the tour of the facility, the surveyor observed no electronic monitoring notice posted	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30330	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

(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
03090	Continued From page 73 in the facility with the statutory required language. On February 7, 2022, at approximately 11:00 a.m., administrator (A)-C acknowledged the licensee failed to post the required electronic monitoring notice. A-C indicated electronic monitoring occurs in the medication room to ensure the security of the medications but no cameras or recording devices would be anywhere else in the facility. The licensee lacked policy and procedure related to electronic monitoring. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *02/11/22*
Time: 12:50:57
Report: 1028221024

Food and Beverage Establishment Inspection Report

Location:
Valleyview Of Northfield
812 Linden Street N
Northfield, MN55057
Rice County, 66

Establishment Info:
ID #: 0038939
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5076454126
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.

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.

The quarternary ammonium test kit must be replaced as it has expired.

Comply By: 02/11/22

4-500 Equipment Maintenance and Operation

4-501.112A ** Priority 2 **

MN Rule 4626.0795A Maintain the temperature at the manifold of the hot water sanitizing rinse at a maximum temperature of 194 degrees F (90 degrees C) and no less than 165 degrees F (74 degrees C) for a single tank, stationary rack, single temperature machine or 180 degrees F (82 degrees C) for all other machines.

The dish machine measured above 180 degrees F.

Discontinue recording the wash cycle temperature on the temperature log for the dish machine. Begin recording the rinse cycle temperature, which needs to be above 180 degrees F.

Comply By: 02/11/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Three Compartment Sink
Violation Issued: No

Hot Water: = at 188 Degrees Fahrenheit
Location: Dish Machine - Rinse
Violation Issued: No

Type: Full
Date: *02/11/22*
Time: 12:50:57
Report: 1028221024
Valleyview Of Northfield

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: -8 Degrees Fahrenheit - Location: Beverage Air Freezer - Ambient
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -1 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: Ham
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Chicken
Violation Issued: No

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

This Inspection was conducted in conjunction with HRD.

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221024 of 02/11/22.

Certified Food Protection Manager: Jodi Sue Heckmann

Certification Number: FM35515 Expires: 08/08/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Rachel Porter
Administrator

Signed: _____
Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us