DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

June 21, 2023

Licensee
Mankato Lodge Senior Living
1360 Adams Street
Mankato, MN 56001

RE: Project Number(s) SL30723015

Dear Licensee:

On June 7, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 6, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

PMB

Electronically Delivered

May 1, 2023

Licensee
Mankato Lodge Senior Living
1360 Adams Street
Mankato, MN 56001

RE: Project Number(s) SL30723015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 6, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH 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.

**STATE CORRECTION ORDERS**
The enclosed State Form documents the state correction orders. The MDH 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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH

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 (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 survey:

**St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00**
**St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00**

**The total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

**DOCUMENTATION OF ACTION TO COMPLY**
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

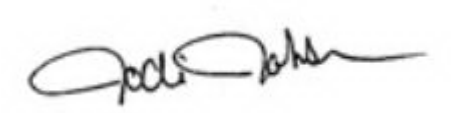
**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30723 | A. BUILDING: _____ B. WING _____ | 04/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MANKATO LODGE SENIOR LIVING | 1360 ADAMS STREET MANKATO, MN 56001 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL#30723015<br><br>On April 3, 2023, through April 6, 2023, 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 57 residents; 25 of whom were receiving services under the provider's Assisted Living Facility license.<br><br>On April 5, 2023, the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of G (level 3, isolated).<br><br>On April 6, 2023, the immediacy of correction order 1290 was removed; however, non-compliance remains at a scope and level of I (level 3, widespread). | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 3, 2023, for the specific Minnesota Food Code deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 650 SS=F | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must | 0 650 | | |

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| 0 650 | Continued From page 2<br>include the following information:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure two of two unlicensed personnel's (ULP-C and ULP-D) records included records of competency evaluations as required.<br><br>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).<br><br>The findings include: | 0 650 | | |

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| 0 650 | Continued From page 3<br><br>ULP-C<br>ULP-C was hired on October 10, 2022, to provide direct care services to residents at the assisted living facility.<br><br>On April 4, 2023, at 7:55 a.m. the surveyor observed ULP-C administer medications and apply compression stockings for R3.<br><br>ULP-C's record lacked evidence of competency evaluation requirements.<br><br>ULP-D<br>ULP-D was hired on March 21, 2023, to provide direct care services to residents at the assisted living facility.<br><br>On April 4, 2023, at 8:15 a.m. the surveyor observed ULP-D administer medications to R2.<br><br>ULP-D's record lacked evidence of competency evaluation requirements.<br><br>On April 6, 2023, at 2:00 p.m. clinical nurse supervisor (CNS)-B confirmed they had not filled out the competency sheet when training staff on required competencies and had utilized the New Employee Orientation Checklist instead. CNS-B further confirmed the checklist identified the training had been completed, but not that competency was achieved.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 650 | | |

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| 0 680 | Continued From page 4 | 0 680 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This had the potential to affect all 25 residents receiving services under the assisted living facility license.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 680 | | |

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| 0 680 | Continued From page 5<br>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 the residents).<br><br>The findings include:<br><br>The licensee's Emergency Preparedness Procedures binder last reviewed December 31, 2022, lacked the following required content:<br>- an all-hazards risk assessment; and<br>- policies and procedures for volunteers.<br><br>On April 6, 2023, at 1:50 p.m. licensed assistant living director (LALD)-A confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z which included the above content.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 730 SS=D | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service | 0 730 | | |

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| 0 730 | Continued From page 6<br>providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the | 0 730 | | |

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| 0 730 | Continued From page 7<br><br>licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R4).<br><br>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).<br><br>The findings include:<br><br>R4's record lacked a discharge summary to include:<br>- diagnoses<br>- allergies<br>- treatments and therapies<br>- pertinent lab, radiology, and consultation results; and<br>- a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status.<br><br>R4 was admitted to the licensee on September 26, 2022, with diagnoses including dementia, diabetes, chronic kidney disease, glaucoma, depression, and irritable bowel syndrome. R6 discharged from the facility on March 7, 2023.<br><br>R4's progress notes dated March 7, 2023, identified the facility the resident was moving to, although it did not contain other required criteria.<br><br>On April 5, 2023, at 11:01 a.m., clinical nurse supervisor (CNS)-B confirmed R4's medical | 0 730 | | |

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| 0 730 | Continued From page 8<br>record did not include a discharge summary with all the required components.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTIONS:<br>Twenty-one (21) days | 0 730 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the path of egress in a manner that allowed the facility to be accessible to fire department services and emergency medical services. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).<br><br>The findings include: | 0 800 | | |

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| 0 800 | Continued From page 9<br><br>On April 05, 2023, from approximately 10:15 a.m. to 12:00 p.m., survey staff toured the facility with Director of Maintenance (DM)-H. During the facility tour, survey staff observed emergency exit doors, on the first floor in the A, B and C wing hallway, did not have the snow removed on the walkway limiting means of egress. This also, limits the accessibility for the fire department and emergency services.<br><br>April 5, 2023, DM-H verbally confirmed survey staff observations.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year | 0 810 | | |

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| | 30723 | A. BUILDING: _____ B. WING _____ | 04/06/2023 |

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| MANKATO LODGE SENIOR LIVING | 1360 ADAMS STREET MANKATO, MN 56001 |

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| 0 810 | Continued From page 10<br>thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on a record review and interview, the licensee failed to provide the required documentation of employee and resident procedures and actions to take when there is a fire or evacuation emergency. This had the potential to affect all staff, residents, and visitors.<br><br>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).<br><br>Findings include:<br><br>A record review and interview were conducted on April 5, 2023, at approximately 11:45 a.m. with | 0 810 | | |

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| 0 810 | Continued From page 11<br><br>Licensed Assisted Living director (LALD)-A and Director of Maintenance (DM)-H on the fire safety and evacuation plan and fire safety and evacuation training for the facility.<br><br>Record review of the fire safety and evacuation plan did not show location and number of residents rooms.<br><br>Record review indicated that the fire safety and evacuation plan did not have fire protection procedures necessary for residents.<br><br>Record review did not indicate the unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency.<br><br>Record review lacked information on employee actions to be taken in the event of a fire or similar emergency.<br><br>During interview, LALD-A and DM-H stated that the fire safety and evacuation plans did not include provisions for these requirements.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 0 950 SS=C | 144G.50 Subd. 3 Designation of representative<br><br>(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: | 0 950 | | |

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| 0 950 | Continued From page 12<br>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.<br><br>You have the right to name anyone as your "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."<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representative statutory language for three of three residents (R2, R3, R1).<br><br>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). | 0 950 | | |

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| 0 950 | Continued From page 13<br><br>The findings include:<br><br>R2's Resident Agreement Assisted Living (contract) was signed on May 20, 2022.<br><br>R3's Resident Agreement Assisted Living (contract) was signed on June 3, 2022.<br><br>R1's Resident Agreement Assisted Living (contract) was signed on July 1, 2022.<br><br>The above residents' contracts were reviewed. Page 1 of the section titled, Resident Agreement: Summary & Disclosure Information, included the following language: "Name and address of Resident's Designated Representative: A Designated Representative is someone who may not have legal authority to act on behalf of a resident but who has been identified by a resident as having authority to receive information and notices about the resident specifically related to the resident's health condition. Although having a Designated Representative can be helpful to both Resident and the Facility, Resident is not obligated to identify such a person."<br><br>R2, R3, and R1's contract and record lacked the following required content:<br>- 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.<br>You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain | 0 950 | | |

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| 0 950 | Continued From page 14<br>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."<br><br>On April 4, 2023, at 10:45 a.m. licensed assisted living director (LALD)-A confirmed R2, R3, and R1's contracts and record lacked the required verbatim content as listed above. LALD-A verified the licensee's contract would lack the same content for all residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 950 | | |
| 0 970 SS=C | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal | 0 970 | | |

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| 0 970 | Continued From page 15<br>property of a resident. This had the potential to affect all residents.<br><br>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).<br><br>The findings include:<br><br>The licensee's assisted living contract included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident.<br>-Page 13, section 24 of the contract indicated: "A. Indemnification. As an occupant of the Community you assume the risk for your own safety and for the safety of your guests and agents. You will indemnify and hold harmless us, our employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of you or your guests or agents."<br><br>On April 4, 2023, at 10:45 a.m. licensed assisted living director (LALD)-A verified the licensee's contract included the above content, and stated the same contract was utilized for all residents at the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 0 970 | | |

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| 0 970 | Continued From page 16<br>(21) days | 0 970 | | |
| 0 980 SS=C | 144G.51 ARBITRATION<br><br>(a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action.<br>(b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the resident agreement arbitration requirement did not include a choice of venue provision.<br><br>This practice resulted in a level one violation 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).<br><br>The findings include:<br><br>The assisted living contract dated May 2022, used for all residents, included a five-page separate section titled, Agreement to Resolve Disputes Through Arbitration, dated May 10, 2022. Page 2, section 3.3 of the document indicated: "Location of Arbitration. The seat of the Arbitration will be in the county in which the Community (assisted living) is located. | 0 980 | | |

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| 0 980 | Continued From page 17<br><br>On April 4, 2023, at 10:45 a.m. licensed assisted living director (LALD)-A confirmed all residents received and signed the Agreement to Resolve Disputes Through Arbitration form as part of the contract. LALD-A further confirmed the choice of law or venue provision was limited to Blue Earth County.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 980 | | |
| 01060 SS=F | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section | 01060 | | |

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| 01060 | Continued From page 18<br><br>144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and<br>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation when the residents had not returned to the facility within four days for two of two residents (R2, R1).<br><br>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).<br><br>The findings include: | 01060 | | |

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| 01060 | Continued From page 19<br>R2<br>R2 was admitted for assisted living services on October 31, 2021.<br><br>R2's Individual Service Plan dated February 7, 2023, indicated R2 received services for bathing, housekeeping, meals, laundry, toileting, and medication administration.<br><br>R2's medical record revealed a Discharge Care Conference/Plan of Care form dated August 5, 2022, from a nursing and rehab center. The form indicated R2 would be discharging back to the assisted living facility on August 9, 2022. R2's RN Comprehensive Assessment dated August 10, 2022, indicated the resident had been hospitalized and then admitted to a short-term rehab facility for bilateral thigh pain and back pain related to a spinal cyst.<br><br>R1<br>R1 was admitted for assisted living services on July 1, 2022.<br><br>R1's Individual Service Plan dated March 29, 2023, indicated R1 received services for dressing including application of compression stockings, bathing, housekeeping, laundry, and medication administration.<br><br>R1's medical record revealed two recent After Visit Summaries from a local hospital. The first After Visit Summary indicated R1 had been hospitalized from February 9, 2023, to February 14, 2023, for shortness of breath. The second After Visit Summary indicated R1 had been hospitalized from March 21, 2023, to March 27, 2023, for sepsis (blood poisoning).<br><br>R2 and R1's records lacked a written notice that | 01060 | | |

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| 01060 | Continued From page 20 | 01060 | | |

contained, at a minimum:
- the reason for the relocation;
- the name and contact information for the location to which the resident has been relocated and any new service provider;
- contact information for the Office of Ombudsman for Long-Term Care;
- if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and
- a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.

On April 4, 2023, at 3:53 p.m. licensed assisted living director (LALD)-A confirmed R2 had been hospitalized on June 29, 2022, and then admitted to a short-term rehab facility prior to returning to the assisted living. LALD-A further confirmed the licensee had not been providing an emergency relocation notice to the resident, legal representative, and designated representative when resident's were hospitalized, nor were they notifying the ombudsman when the relocation exceeded four days. LALD-A stated being unaware of the requirement.

a written notice related to R2 and R1's emergency relocation had not been completed, and further lacked notification to the Office of Ombudsman for Long-Term Care within four days that R2 and R1 had been relocated and had not returned to the facility.

The licensee's Emergency Relocation policy dated July 27, 2022, indicated:

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| 01060 | Continued From page 21<br><br>1. In the event of an emergency relocation, the community will provide a written notice that contains, at a minimum:<br>A. The reason for the relocation.<br>B. The name and contact information for the location to which the resident has been relocated and any new service provider<br>C. Contact information for the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities<br>D. If known, and applicable, the approximate date or range of dates within which the resident is expected to return to the community, or a statement that a return date is not currently known, and<br>E. A statement that, if the community refuses to provide housing or services after a relocation, the resident has the right to appeal.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01060 | | |
| 01290 SS=I | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of an employee in good faith | 01290 | | |

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| 01290 | Continued From page 22 | 01290 | | |

reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure a background study had been completed prior to providing services for two of five employees (unlicensed personnel (ULP)-C and ULP-E). This had the potential to affect all residents living within the facility. This resulted in an immediate correction order on April 5, at 4:25 p.m.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

ULP-C
ULP-C began providing direct care services for the licensee under the assisted living facility (ALF) license on October 10, 2022.

ULP-C's employee file included a background study dated April 4, 2023, which revealed the applicant was not previously determined eligible for employment and must be fingerprinted. The NETStudy 2.0 website indicated ULP-C would need to be supervised when providing direct care.

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| MANKATO LODGE SENIOR LIVING | 1360 ADAMS STREET MANKATO, MN 56001 |

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| 01290 | Continued From page 23<br>On April 4, 2023, at 7:30 a.m. ULP-C was observed independently administering medications to R1 inside of R1's room.<br><br>ULP-E<br>ULP-E began providing direct care services for the licensee under the ALF license on November 29, 2022.<br><br>ULP-E's employee file included a background study dated November 17, 2022, which revealed the applicant was not previously determined eligible for employment and must be fingerprinted by December 8, 2022.<br><br>Upon review of the NETStudy 2.0 website, ULP-E was not included in the licensee's roster. The licensee lacked evidence a background study had been completed prior to ULP-E providing direct care services under the ALF license.<br><br>On April 5, 2023, at 4:25 p.m. licensed assistant living director (LALD)-A confirmed ULP-C and ULP-E both still worked at the facility and worked unsupervised. LALD-A stated she "caught" ULP-C's need to be fingerprinted "yesterday" when looking at her employee file but was unsure if ULP-C had gone in yet to complete the fingerprinting process. LALD-A stated having no knowledge ULP-E was not cleared.<br><br>The licensee's Background Checks policy dated August 24, 2021, indicated all employees; as well as contractors, and regularly scheduled volunteers of the community with direct resident contact with undergo a background study through DHS (Department of Human Services). Only those with satisfactory results will continue to work with the community and its residents. | 01290 | | |

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| 01290 | Continued From page 24<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate<br><br>On April 6, 2023, the immediacy of correction order 1290 was removed based on observations by the surveyor and record reviews by the evaluation supervisor; however, non-compliance remains at a scope and level of (I).<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 01290 | | |
| 01440 SS=F | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(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.<br>(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. | 01440 | | |

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| 01440 | Continued From page 25<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure direct supervision of two of two unlicensed personnel (ULP-C and ULP-D) performing delegated tasks was provided within 30 calendar days after the date on which the individuals began working for the licensee.<br><br>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).<br><br>The findings include:<br><br>ULP-C<br>ULP-C was hired on October 10, 2022, to provide direct care services to residents at the assisted living facility.<br><br>On April 4, 2023, at 7:55 a.m. the surveyor observed ULP-C administer medications and apply compression stockings for R3.<br><br>ULP-C's employee record did not include a 30-day direct supervisory review.<br><br>ULP-D<br>ULP-D was hired on March 21, 2023, to provide direct care services to residents at the assisted living facility.<br><br>On April 4, 2023, at 8:15 a.m. the surveyor | 01440 | | |

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| 01440 | Continued From page 26<br>observed ULP-D administer medications to R2.<br><br>ULP-C's employee record did not include a 30-day direct supervisory review.<br><br>On April 6, 2023, at 10:15 a.m. licensed assisted living director (LALD)-A confirmed they had not been performing 30-day supervision of delegated tasks for new employees and was not aware of the requirement.<br><br>The licensee's Employee Records, Training Requirements, and Employee Orientation policies all dated August 24, 2021, did not include the 30-day supervision of delegated tasks requirement for new direct care staff employees.<br><br>No further information as provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01440 | | |
| 01530 SS=D | 144G.64 TRAINING IN DEMENTIA CARE REQUIRED<br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(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 | 01530 | | |

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| 01530 | Continued From page 27<br>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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-C) received the required amount of dementia care training in the required time frame.<br><br>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).<br><br>The findings include:<br><br>The licensee provided services under an Assisted Living Facility license.<br><br>ULP-C was hired on October 10, 2022, to provide direct care services to the licensee's residents.<br><br>ULP-C's employee record contained evidence the | 01530 | | |

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| 01530 | Continued From page 28<br>employee received three hours and 30 minutes of dementia care training, not the required eight hours of training within 160 working hours of the employment start date as required.<br><br>On April 6, 2023, at 10:15 a.m. licensed assistant living director (LALD)-A confirmed ULP-C had not completed the required eight hours of dementia training within 160 hours of the employment start date.<br><br>The licensee's Employee Orientation policy dated August 24, 2021, indicated: 1. All assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. 5. Dementia Training.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01530 | | |
| 01650 SS=E | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service | 01650 | | |

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| 01650 | Continued From page 29<br>cannot be provided;<br>(ii) information and a method to contact the facility;<br>(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<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure resident service plans included all the required content for three of three residents (R1, R2, R3).<br><br>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).<br><br>The findings include:<br><br>R1<br>R1 was admitted for assisted living services on July 1, 2022, with diagnoses including diabetes, neuropathy, and atrial fibrillation. | 01650 | | |

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| 01650 | Continued From page 30<br><br>R1's Individual Service Plan dated March 29, 2023, indicated R1 received services for bathing, housekeeping, meals, treatments, laundry, and medication administration.<br><br>On April 4, 2023, at 7:30 a.m. unlicensed personnel (ULP)-C was observed administering medications to R1.<br><br>R1's service plan lacked the following content:<br>- the identification of staff or categories of staff who will provide the services.<br><br>R2<br>R2 was admitted for assisted living services on October 31, 2021, with diagnoses including cancer and multiple sclerosis.<br><br>R2's Individual Service Plan dated February 7, 2023, indicated R2 received services for bathing, housekeeping, meals, laundry, toileting, and medication administration.<br><br>On April 4, 2023, at 8:15 a.m. unlicensed personnel (ULP)-D was observed administering medication to R2.<br><br>R2's service plan lacked the following content:<br>- 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<br>- the identification of staff or categories of staff who will provide the services.<br><br>R3 | 01650 | | |

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| 01650 | Continued From page 31<br><br>R3 was admitted to the facility on February 1, 2021, and began receiving assisted living services on August 1, 2021. R3's diagnoses included chronic low back pain, history of falls, macular degeneration, memory loss, peripheral neuropathy, and spinal stenosis.<br><br>R3's Individual Service Plan dated April 3, 2023, indicated R3 received services for dressing, grooming, bathing, meals, toileting, housekeeping, laundry, treatments, and medication administration.<br><br>On April 4, 2023, at 7:55 a.m. ULP-C was observed administering medication and applying compression stockings for R3.<br><br>R3's service plan lacked the following content:<br>- the identification of staff or categories of staff who will provide the services.<br><br>On April 5, 2023, at 12:15 p.m. clinical nurse supervisor (CNS)-B confirmed R2's Service Plan did not include an emergency contact or categories of staff who would provide services. CNS-B further confirmed R1 and R3's Service Plans did not include the categories of staff who would provide all services.<br><br>The licensee's Service Plan contents policy revised July 29, 2022, indicated:<br>5. Service plans will include:<br>d. Identification of staff or categories of staff who will be providing services<br>h. A contingency plan that includes:<br>iii. Names and contact information of persons the resident wishes to have notified in an emergency<br>iv. Names and contact information of persons the resident wishes to have notified if | 01650 | | |

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| 01650 | Continued From page 32<br>there is a significant adverse change in the resident's condition<br>v. Identification of and information on who has authority to sign for the resident in an emergency<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days. | 01650 | | |
| 01760 SS=D | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for 1 of 3 residents (R3).<br><br>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 | 01760 | | |

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| 01760 | Continued From page 33 | 01760 | | |

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R3's diagnoses included peripheral neuropathy (disease affecting peripheral nerves that causes weakness, numbness and pain in feet and hands), pain of right lower extremity, and generalized osteoarthritis of multiple sites.

R3's Individualized Service Plan dated April 3, 2023, indicated R3 received medication administration.

R3's physician note dated February 2, 2023, indicated R3's family member was concerned about the resident's foot pain and requested an order for Voltaren gel (used to treat pain and inflammatory diseases). A new order was given to start diclofenac sodium (generic version of Voltaren gel) 1% external gel; apply 2 grams to affected areas (bilateral feet) BID (twice a day).

On April 4, 2023, at 7:55 a.m. unlicensed personnel (ULP)-C was observed administering medications (including diclofenac sodium gel) to R3. When administering R3's diclofenac sodium gel, ULP-C first put on clean gloves then applied approximately a quarter size of gel into the palm of her left hand. ULP-C then applied the gel with her right hand to R3's knees, ankles, and top of feet. When asked about applying to R3's knees and ankles, ULP-C stated she'd been told to apply it to R3's knees as they were giving her trouble and further stated it was a "personal

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| 01760 | Continued From page 34<br>preference". After exiting R3's apartment, the surveyor asked ULP-C how she measured two grams of the diclofenac sodium gel per the physician order. ULP-C confirmed she had not measured the amount of gel applied and should have.<br><br>On April 5, 2023, at 11:01 a.m. clinical nurse supervisor (CNS)-B confirmed expectation that topical gels and ointments be measured for accuracy per physician order and only to areas specified in the order.<br><br>The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated May 20, 2022, indicated:<br>2. Medications, treatment and therapy always need to be administered according to the "6 rights" of administration:<br>A. Right Person<br>B. Right Medication, treatment or therapy<br>C. Right time<br>D. Right route (by mouth, eye drops, to the skin, etc.)<br>E. Right dose (how many milligrams, drops, etc.)<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 01760 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the | 01890 | | |

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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 |
|---|---|---|---|---|
| 01890 | Continued From page 35<br>expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications had an opened date for 1 of 1 resident (R1).<br><br>The findings include:<br><br>R1's diagnoses included diabetes.<br><br>R1's Individual Service Plan dated March 29, 2023, indicated R1 received medication administration.<br><br>On April 4, 2023, at 7:30 a.m. ULP-C was observed setting up medication to administer for R1. While preparing R1's Humulin insulin Kwikpen, the surveyor noted there was no date when opened on the pen. ULP-C confirmed the insulin pen was not dated when opened then checked the insulin level on the pen and stated it hadn't been open long. ULP-C then administered R1's medications including the undated insulin.<br><br>On April 5, 2023, at 11:01 a.m. clinical nurse supervisor (CNS)-B confirmed insulin needed to be dated when opened and would expect the ULP to contact the nurse if it hadn't been.<br><br>The Humulin Kwikpen Instructions For Use revised June 2022, indicated to throw away an opened insulin pen after using it for 14 days, even if there is insulin left in it.<br><br>The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30723 | A. BUILDING: _____ B. WING _____ | 04/06/2023 |

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| 01890 | Continued From page 36<br>policy dated May 20, 2022, indicated:<br>2. Medications, treatment and therapy always need to be administered according to the "6 rights" of administration:<br>A. Right Person<br>B. Right Medication, treatment or therapy<br>C. Right time<br>D. Right route (by mouth, eye drops, to the skin, etc.)<br>E. Right dose (how many milligrams, drops, etc.)<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 01890 | | |
| 01910 SS=D | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.<br>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.<br>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other | 01910 | | |

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| 01910 | Continued From page 37<br>individuals involved in the disposition.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's prescription number as applicable, for one of one discharged resident (R4).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>The discharge resident roster provided by the licensee, indicated R4 discharged on March 7, 2023, to another facility.<br><br>R4's Individual Service Plan dated March 2, 2023, indicated services included medication administration.<br><br>R4's Discharge/Leave of Absence Medication form dated March 7, 2023, included medications that had been sent with R4's family member upon discharge. The document identified the medication name, strength, quantity, dosing instructions and signature of the nurse and family member. The document did not include the prescription number for any of the identified medications including aspirin, simvastatin (for high cholesterol), doxycycline hyclate (antibiotic), | 01910 | | |

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| 01910 | Continued From page 38<br>oxybutynin (for overactive bladder), Vitamin D, citalopram (antidepressant), and donepezil (to treat confusion related to dementia).<br><br>On April 5, 2023, at 11:01 a.m. clinical nurse supervisor (CNS)-B confirmed the facility's Discharge/Leave of Absence Medication form used for reconciliation of medications, did not include the prescription number as required.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |
| 02310 SS=G | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for two of two residents (R3, R5) with side rails. This resulted in an immediate correction order on April 3, 2023, at approximately 1:45 p.m.<br><br>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 | 02310 | | |

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| 02310 | Continued From page 39 | 02310 | | |

issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R3
R3's diagnoses included history of a right hip fracture and chronic low back pain.

R3's Service Plan dated November 29, 2022, included daily medication administration and activities of daily living (ADLs).

On April 3, 2023, during the entrance conference at approximately 10:20 a.m., clinical nurse supervisor (CNS)-B indicated there were some residents in the facility that utilized side rails. CNS-B stated sometimes a family member would bring a side rail into the building and attach it to the resident's bed without telling the staff. CNS-B stated they were working on educating families about consulting with staff prior to installing a side rail to discuss the risks and to assess for safety.

On April 3, 2023, at 12:59 p.m., CNS-B stated there was only one resident (R3) in the building with a side rail. CNS-B stated R3's family brought it in and attached it to the resident's bed without informing staff. CNS-B confirmed the side rail had been on R3's bed at least one week. CNS-B stated she talked with R3's daughter about the risks/benefits of the side rail over the phone but had not gotten a signature from her yet. CNS-B confirmed she did not complete the side rail assessment until today when the surveyor asked for a list of residents utilizing side rails. CNS-B stated R3's son threw the side rail instructions away and she had not yet researched to see if

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| 02310 | Continued From page 40<br>she could figure out what kind of side rail it was, though it looked like an M rail.<br><br>On April 3, 2023, at 1:25 p.m., surveyor observed R3's bed; and the side rail had been removed. R3 was unaware staff had removed the side rail and stated it was still there when she got out of bed that morning.<br><br>R3's side rail assessment dated April 3, 2023, (after the initiation of the survey), indicated the family had been notified today about the risks and benefits of side rail use, and gave their verbal acknowledgement.<br><br>R3's record lacked documentation of a timely side rail assessment, timely documentation of a risk versus benefits discussion, and documentation that R3's side rail was installed, used, and maintained per manufacturer's guidelines.<br><br>R5<br>R5's diagnoses included history of pelvic fracture and history of right femur fracture.<br><br>R5's Service Plan dated January 11, 2023, included daily medication administration and assistance with ADLs.<br><br>R5's record lacked a side rail assessment, documentation of risk versus benefits discussion, documentation of the measurements of R5's side rail, and documentation R5's side rail was Food and Drug Administration (FDA) compliant.<br><br>On April 3, 2023, at 1:40 p.m., CNS-B stated she had called their regional nurse who advised her to remove R3's side rail until they had everything in place. R3's side rail was observed on the floor in the nurse's office. CNS-B also stated she asked | 02310 | | |

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| 02310 | Continued From page 41<br>staff if there were any more rails in the building and they confirmed R5 also had a hospital side rail. R5's son was at the desk outside of the nurse's office at the time. CNS-B stated she had him remove the side rail. Surveyor expressed the rail did not need to be removed though it did need to be assessed for safety. R5's son was upset that he was directed to remove the rail and stated R5 had the side rail since she moved into the facility 9 months ago.<br><br>The March 10, 2006, the FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches.<br><br>The 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."<br><br>The licensee's Supportive Devices policy revised December 12, 2022, indicated an assessment must be completed by a licensed nurse (Supportive Device Assessment) prior to implementing any supportive device. Any bedside mobility device will need a Bedside Mobility Disclosure From filled out and signed for the resident by the responsible party. | 02310 | | |

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| 02310 | Continued From page 42<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate<br><br>On April 5, 2023, the immediacy of correction order 2310 was removed based on observations by the surveyor and record reviews by the evaluation supervisor; however, non-compliance remains at a scope and level of (G).<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 02310 | | |

Minnesota Department of Health
Division of Environmental Health
Food, Pools, and Lodging
12 Civic Center Plaza, Se 2105
Mankato, MN

Type: Full
Date: *04/04/23*
Time: 12:17:13
Report: 1028231074

# Food and Beverage Establishment Inspection Report



**Location:**
Mankato Lodge Senior Living
1360 Adams Street
Mankato, MN56001
Blue Earth County, 07

**Establishment Info:**
ID #: 0038170
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 5073889292
ID #:

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

The following orders were issued during this inspection.

**3-800 Highly Susceptible Populations**

3-801.11B ** Priority 1 **

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

Provide pasteurized eggs or egg products when preparing food for residents. The exception to this is if the raw eggs are combined immediately before cooking for one consumer's serving at a single meal and cooked to at least 145 F.

*Comply By: 04/04/23*

**Surface and Equipment Sanitizers**

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Hot Water: = at 185 Degrees Fahrenheit
Location: Dish Machine - Rinse
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Upright Freezer
Temperature: -2 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 38 Degrees Fahrenheit - Location: Sliced Tomatoes
Violation Issued: No

Type: Full
Date: *04/04/23*
Time: 12:17:13
Report: 1028231074
Mankato Lodge Senior Living

# Food and Beverage Establishment Inspection Report

Process/Item: Prep Cooler
Temperature: 39 Degrees Fahrenheit - Location: Roast Beef
Violation Issued: No

Process/Item: Hot Holding
Temperature: 145 Degrees Fahrenheit - Location: Mashed Potatoes
Violation Issued: No

Process/Item: Hot Holding
Temperature: 175 Degrees Fahrenheit - Location: Chicken
Violation Issued: No

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

| Total Orders In This Report | Priority 1 | Priority 2 | Priority 3 |
|---|---|---|---|
| | 1 | 0 | 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 Department of Health inspection report number 1028231074 of 04/04/23.

Certified Food Protection Manager: Lora L. McCaulley

Certification Number: FM3427 Expires: 08/16/24

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
Lora L. McCaulley
Food Service Director

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