Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 22, 2022

Administrator
Rosewood Senior Living, LLC
801 Main Street North
Cambridge, MN 55008

RE: Project Number(s) SL27286015

Dear Administrator:

On March 3, 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 September 10, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the September 10, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on September 10, 2021, found not corrected at the time of the March 3, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0340-Correction Orders-144g.30 Subd. 5 = $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on March 3, 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 $1,000.00**. 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 Jessica Chenze at 651-508-2791.

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,

Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-508-2791 Fax: 651-215-9697

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27286	A. BUILDING: ______ B. WING ______	R 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD SENIOR LIVING LLC	**801 MAIN STREET NORTH CAMBRIDGE, MN 55008**

(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: SL27286015 On March 3, 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 September 10, 2021, and revisit surveys completed on November 22, 2021, and January 24, 2022. At the time of the survey, there were 23 active residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{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.	
{0 340} SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	{0 340}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{0 340}	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on January 24, 2022, 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	{0 340}		

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{0 340}	Continued From page 2 of the residents). The findings include: During the revisit survey on March 3, 2022, the surveyor reviewed the licensee's policies and procedures, employee records, and conducted interviews with licensed assisted living director (LALD)-H and office administrator (OA)-I. The licensee lacked evidence to indicate the orders issued on January 24, 2022, were corrected. No further information was provided.	{0 340}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding 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	{0 680}		

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{0 680}	Continued From page 3 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide training and testing of the emergency preparedness (EP) plan with the required content. This had the potential to affect all 23 current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the follow-up survey on March 3, 2022, at approximately 10:03 a.m., licensed assisted living director (LALD)-H stated the emergency preparedness plan with the required content had not been provided as training to the staff as required. LALD-H stated she had only talked with the staff that would be involved in providing the training and planned to provide training to staff starting March 10, 2022, but had nothing in writing. The training would continue each Thursday until all staff were trained. In addition, LALD-H confirmed no testing program had been competed as required. The licensee's Plans For Natural Disasters and	{0 680}		

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{0 680}	Continued From page 4 Emergencies dated January 20, 2021, noted the licensee would have a written plan of action to facilitate the resident's care and services in response to a natural disaster or another type of emergency that could affect the ability to provide services. The policy indicated the requirements include having a written disaster plan as described above, emergency and disaster training to all staff during the initial orientation and annually thereafter, and conducting and documenting emergency drills at least every six months, coordinated to the extent possible with local fire departments or other community emergency resources. No further information was provided.	{0 680}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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. This MN Requirement is not met as evidenced by: No further information required.	{0 800}		
{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	{0 810}		

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{0 810}	Continued From page 5 rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further information required.	{0 810}		
{01380} SS=D	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:	{01380}		

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{01380}	Continued From page 6 (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 evaluations were completed as required prior to providing direct care to residents for one of three unlicensed personnel (ULP)-M with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-M's employee record lacked evidence to indicate the employee had completed training as required in the following area: - recognizing physical, emotional, cognitive, and	{01380}		

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{01380} Continued From page 7 {01380}

developmental needs of the resident.

ULP-M started employment on January 20, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

ULP-M's employee record contained transcripts of courses completed but lacked evidence of completion of the above required training.

On March 3, 2022, at approximately 10:03 a.m., licensed assisted living director (LALD)-H and office administrator (OA)-I confirmed the above required training had not been completed by ULP-M.

The licensee's Training and Competency Evaluation of Unlicensed Staff policy, dated January 24, 2020, indicated required content for ULP training included recognizing physical, emotional, cognitive, and developmental needs of the client [resident].

No further information was provided.

{01530} SS=D 144G.64 TRAINING IN DEMENTIA CARE REQUIRED {01530}

(a) All assisted living facilities must meet the following training requirements:
(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;
(2) direct-care employees must have completed

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{01530}	Continued From page 8 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 interview and record review, the licensee failed to ensure one of two unlicensed personnel ((ULP)-M) received the required amount of dementia care training, in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee provided services under an assisted living license. The licensee's website indicated services included memory care.	{01530}		

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{01530}	Continued From page 9	{01530}		

ULP-M started employment on January 20, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

ULP-M's record contained evidence the employee had received 7.5 hours dementia related training, short of the required 8.0 hours initial training.

On March 3, 2022, at approximately 10:03 a.m., licensed assisted living director (LALD)-H and office administrator (OA)-I confirmed ULP-M was short 0.5 hours on the required dementia care training.

The licensee's Dementia Care Training For Home Care Employees/Staff providing Home Care Services in Housing with Services Establishments with Dementia Programs and/or Assisted Living Services policy, undated, noted direct-care staff hired after January 1, 2016, would complete at least four hours of initial training within 160 working hours.

No further information was provided.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 8, 2022

Administrator
Rosewood Senior Living, LLC
801 Main Street North
Cambridge, MN 55008

RE: Project Number(s) SL27286015

Dear Administrator:

On January 24, 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 September 10, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the September 10, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on September 10, 2021, found not corrected at the time of the January 24, 2022 follow-up evaluation and subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on January 24, 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 $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on January 24, 2022, we identified the following violation(s):

0110-Assisted Living Director License Required-144g.10 Subdivision 1a
0340-Correction Orders-144g.30 Subd. 5

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

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.

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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:

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Minnesota Department of Health
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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 Casey DeVries at 651-201-5917.

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,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

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ROSEWOOD SENIOR LIVING LLC	**801 MAIN STREET NORTH CAMBRIDGE, MN 55008**

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{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: SL27286015-2 On January 21, 2022, through January 24, 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 September 10, 2021, and a revisit survey completed on November 22, 2021. At the time of the survey, there were 22 active residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{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=C	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 a licensed assisted living director was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's 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 of the residents). The findings include: Licensed assisted living director (LALD)-A had a license effective through October 31, 2022. However, LALD-A's license lacked an organization listed as the Director of Record with BELTSS. LALD-H had a license effective through October 31, 2022. However, LALD-H's license lacked an organization listed as the Director of Record with BELTSS. Office administrator (OA)-I had a license effective through October 31, 2022. However, OA-I's license lacked an organization listed as the	0 110		

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0 110	Continued From page 2 Director of Record with BELTSS. On January 25, 2022, at 1:48 p.m., the surveyor placed a call to LALD-A, and left a voice message asking for a return call to discuss information on the LALD license. LALD-A did not return the call. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.	0 340		

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0 340	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on November 22, 2021, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the revisit survey on January 21, 2022, and January 24, 2022, the surveyor reviewed the licensee's policies and procedures, resident records, employee records, and conducted interviews with licensed assisted living director (LALD)-A, LALD-H and office administrator (OA)-I. The licensee lacked evidence to indicate the orders issued on November 22, 2021, were corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

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{0 680}	Continued From page 4 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all 22 current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	{0 680}		

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{0 680}	Continued From page 5	{0 680}		

cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

During the follow-up survey desk audit on January 21, 2022, at approximately 1:41 p.m., the licensed assisted living director (LALD)-H provided the surveyor the licensee's emergency preparedness (EP) plan documents via email.

The EP plan lacked the following required content:
- a comprehensive program to include infectious diseases and pandemics;
- development of policies/procedures to address:
  - the medical record documentation system to preserve resident information;
- a communication plan that included:
  - a method of sharing information and medical documentation for residents;
  - a method of sharing information from the emergency plan with residents and their families;
- EP training and testing program;
- EP training program for staff (including documentation of training provided); and
- EP testing/annual testing requirements.

During a telephone interview on January 21, 2022, at approximately 4:20 p.m., LALD-H verified the plan lacked the above content and stated she continued to work on the EP plan because she hadn't had enough time due to several factors. In addition, LALD-H stated the EP plan was not posted in a prominent place.

On January 24, 2022, at approximately 6:56 a.m.,

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{0 680}	Continued From page 6	{0 680}		
	LALD-H sent additional information via email that included a portion of the required content, which was lacking when the follow up survey was initiated on January 21, 2022; however, still lacked the following: - a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided to current staff); and - EP testing/annual testing requirements. During a telephone interview on January 24, 2022, at approximately 11:10 a.m., LALD-H stated she worked on the EP plan over the weekend and had completed the content that was missing; however, verified the EP plan was not complete when the follow up survey was initiated. In addition, LALD-H stated she planned to share information from the EP plan with residents and their families by using the "flip cards" that were currently hanging in the kitchenettes; however, during the initial survey on September 10, 2021, at 8:33 a.m., ALD-A stated the "flip card" was not posted in a prominent location as required because staff and residents had to reach up and over the sink to pull it off the hook attached to the wall. No further information was provided.			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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	{0 800}		

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{0 800}	Continued From page 7 health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		
{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. (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	{0 810}		

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{0 810}	Continued From page 8 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}		
{01380} SS=E	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 evaluations were completed as required prior to providing direct care to residents for two of two unlicensed personnel ((ULP)-J and ULP-L) with records reviewed.	{01380}		

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{01380}	Continued From page 9	{01380}		

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:

ULP-J and ULP-L's employee records lacked evidence to indicate the employees had completed training as required in the following area:
- recognizing physical, emotional, cognitive, and developmental needs of the resident.

ULP-J
ULP-J started employment on September 24, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

ULP-J's employee record contained transcripts of courses completed but lacked evidence of completion of the above required training.

ULP-L
ULP-L started employment on June 2, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

ULP-L's employee record contained transcripts of courses completed but lacked evidence of completion of the above required training.

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{01380}	Continued From page 10 On January 24, 2022, at approximately 11:00 a.m., office administrator (OA)-I confirmed ULP-J and ULP-L lacked the above required training content. The licensee's Training and Competency Evaluation of Unlicensed Staff policy, dated January 24, 2020, indicated required content for ULP training included recognizing physical, emotional, cognitive, and developmental needs of the client [resident]. No further information was provided.	{01380}		
{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 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	{01530}		

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{01530}	Continued From page 11 until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two unlicensed personnel ((ULP)-L) received the required amount of dementia care training, in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee provided services under an assisted living license. The licensee's website indicated services included memory care. The licensee's current resident list, undated, provided to the surveyor upon entrance, identified residents with the diagnoses of dementia and cognitive impairment. ULP-L started employment on June 2, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-L's record contained evidence the employee	{01530}		

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{01530}	Continued From page 12 had received 7.75 hours dementia related training, short of the required 8.0 hours initial training. On January 24, 2022, at approximately 11:00 a.m., office administrator (OA)-I confirmed ULP-L lacked the required 8.0 hours required training. ULP-L had reached 160 working hours on July 23, 2021. The licensee's Dementia Care Training For Home Care Employees/Staff providing Home Care Services in Housing with Services Establishments with Dementia Programs and/or Assisted Living Services policy, undated, noted direct-care staff hired after January 1, 2016, would complete at least four hours of initial training within 160 working hours. No further information was provided.	{01530}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 3, 2021

Administrator
Rosewood Senior Living, LLC
801 Main Street North
Cambridge, MN 55008

RE: Project Number(s) SL27286015-1

Dear Administrator:

On November 22, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on September 10, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the September 10, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on September 10, 2021, found not corrected at the time of the November 22, 2021 follow-up evaluation and subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - $500.00
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2
1530-Training In Dementia Care Required-144g.64
1650-Service Plan, Implementation, And Revisions T-144g.70 Subd. 4

The details of the violations noted at the time of this follow-up evaluation completed on November 22, 2021 (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 $1,500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on November 22, 2021, we identified the following violation(s):

1640-Service Plan, Implementation, And Revisions T-144g.70 Subd. 4

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

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. 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

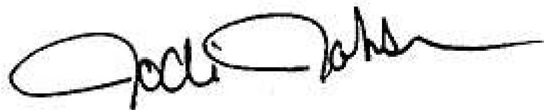
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 16, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. 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 Jodi Johnson at 507-344-2730.

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,



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

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27286	A. BUILDING: ______ B. WING ______	R 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD SENIOR LIVING LLC	**801 MAIN STREET NORTH CAMBRIDGE, MN 55008**

(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 # SL27286015 On November 22, 2021, surveyors of this Department's staff conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 10, 2021. At the time of the survey, there were 25 active residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{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.A 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.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

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{0 680}	Continued From page 1 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding 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 (EP) plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all 25 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	{0 680}		

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{0 680}		{0 680}		

Continued From page 2

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

During the follow-up survey entrance conference on November 22, 2021, at approximately 12:05 p.m., the licensed assisted living director (LALD)-A provided the licensee's emergency preparedness plan.

The EP plan lacked the following required content:
- a comprehensive program to include infectious diseases and pandemics;
- development of policies/procedures to address:
  - the medical record documentation system to preserve resident information;
  - emergency staff strategies including surge planning and use of volunteers;
  - the facility's role in providing care and treatment at alternative sites;
- a communication plan that included:
  - a method of sharing information and medical documentation for residents;
  - a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy;
  - -a method of sharing information from the emergency plan with residents and their families;
- EP training and testing program;
- EP training program for staff (including documentation of training provided); and
- EP testing/annual testing requirements.

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{0 680}	Continued From page 3 During a tour of the facility on November 22, 2021, at approximately 12:45 p.m., there was no observed signage posted or information regarding the licensee's emergency plan in the main entrances or elsewhere in the facility. On November 22, 2021, at approximately 1:38 p.m., per telephone interview, LALD-H verified the above content was missing from the EP plan and stated she was still working on it. LALD-H also indicated the plan was not posted yet, staff had not been trained on the plan, and the plan had not been tested as required, because it was not complete. No further information was provided.	{0 680}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the building's physical environment including walls and floors in a continuous state of good repair and operation for health, comfort, and well-being of residents in accordance with a maintenance and repair program. This had the potential to affect all residents and staff.	{0 800}		

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{0 800}	Continued From page 4	{0 800}		

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 November 22, 2021, between 1:30 p.m., and 3:20 p.m., survey staff toured with the licensed assisted living director (LALD)-A. The following findings were verified doing the tour.

FLOORS:
Flooring in small kitchen on first floor where the facility had a previous refrigerator leakage had not been repaired.

Flooring transition strips were damaged in Room 107, where previously created sharp edges and tripping hazards, had been temporarily taped over and had not been repaired.

WALLS:
Paint near shower head in bathroom #115 was peeling from water leakage/damage, which had the potential for mold growth over time, had not been repaired.

On November 22, 2021, at 3:20 p.m., LALD-A acknowledged the findings and stated the facility was working on an agreement with a contractor and could obtain a copy of the contract to show to repair for the floors and wall work. Survey staff requested the copy be sent via email for review by end of day.

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{0 800}	Continued From page 5 Additional information was provided to survey staff via email on November 28, 2021, at 8:46 p.m., regarding the licensee having secured a contractor to perform the repair of the floors and walls with the contractor scheduled to begin November 30, 2021.	{0 800}		
{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. (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	{0 810}		

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{0 810}	Continued From page 6	{0 810}		

the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide the required employee training and failed to complete the required evacuation drills.

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 November 22, 2021, at approximately 2:00 p.m., survey staff requested record of employee fire drills, and training on fire safety and evacuation plans and procedures.

Fire drill records provided indicated one fire drill had been performed on November 1, 2021. The licensee lacked a sufficient number of fire drills performed to date, as the minimum of six fire drills were required per year, or at least one fire drill every other month.

On November 22, 2021, at approximately 3:10 p.m., licensed assissted living director (LALD)-A confirmed the findings and stated the training of employees and residents would be provided as soon as the licensee completed their revised facility fire safety and evacuation plan and

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{0 810}	Continued From page 7 procedures, which were currently being finalized. LALD-A also stated the licensee had provided new employee onboard training but had no documented records to substantiate that training. No further information was provided.	{0 810}		
{01380} SS=E	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 evaluations were completed as required prior to providing direct care to residents for two of two unlicensed personnel (ULP)-E and ULP-J with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{01380}		

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{01380}	Continued From page 8	{01380}		

safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).
The findings include:
ULP-E and ULP-J's employee records lacked evidence to indicate the employees had completed training as required in the following area:
- recognizing physical, emotional, cognitive, and developmental needs of the resident

ULP-E
ULP-E started employment on July 27, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

ULP-E's employee record contained transcripts of courses completed but lacked evidence of completion of the above required training.

ULP-J
ULP-J started employment on September 24, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

ULP-J's employee record contained transcripts of courses completed but lacked evidence of completion of the above required training.

On November 22, 2021, at approximately 3:10 p.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the above required training was not available in the

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{01380}	Continued From page 9 employee records as required and were not able to state whether the training had been completed or not. The licensee's Training and Competency Evaluation of Unlicensed Staff policy, dated January 24, 2020, indicated required content for ULP training included recognizing physical, emotional, cognitive, and developmental needs of the client [resident]. No further information was provided.	{01380}		
{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 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.	{01530}		

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{01530}	Continued From page 10	{01530}		

Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure one of four employees (E) received the required amount of dementia care training, in the required time frame.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

The licensee provided services under an assisted living license. The licensee's website indicated services included memory care.

The licensee's current resident list, undated, provided on entrance, identified residents with the diagnoses of dementia, cognitive impairment, and Alzheimer's disease.

Unlicensed personnel (ULP)-E started employment on July 27, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

ULP-E's record contained evidence the employee had received 6.0 hours dementia related training,

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{01530}	Continued From page 11 short of the required 8.0 hours initial training. In addition, ULP-E's record lacked evidence of dementia training to include assistance with activities of daily living. On November 22, 2021, at approximately 3:10 p.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the above required training had not been completed. The licensee's Dementia Care Training For Home Care Employees/Staff providing Home Care Services in Housing with Services Establishments with Dementia Programs and/or Assisted Living Services policy, undated, noted direct-care staff hired after January 1, 2016, would complete at least four hours of initial training within 160 working hours. No further information was provided.	{01530}		
01640 SS=C	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all	01640		

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01640	Continued From page 12	01640		

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 service plan included a signature or other authentication by the resident to document agreement on the services to be provided for five of five residents (R1, R2, R3, R7, R8) 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 of the residents).

The findings include:

During the follow up survey entrance conference on November 22, 2021, at approximately 12:10 p.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B indicated the service plan for all residents had been updated to include all of the required content, and all residents had resigned the updated service plan.

R1
R1's Individual Service Plan, dated November 2, 2021, indicated R1's services included dining and special diets, assistance with dressing, grooming,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27286	A. BUILDING: ____ B. WING ____	R 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD SENIOR LIVING LLC	**801 MAIN STREET NORTH CAMBRIDGE, MN 55008**

(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
01640	Continued From page 13 bathing, ambulation, mobility, transfer, communication, memory and orientation, continence and toileting, instrumental activities of daily living, and medication administration. The Individual Service Plan included RN-B's signature, dated October 4, 2021; however, lacked the resident or resident's representative's signature to document agreement on the services to be provided. R2 R2's Individual Service Plan, dated November 2, 2021, indicated R2 received services including, but not limited to, assistance with grooming, hygiene, bathing, transfers, and medication management. The Individual Service Plan included RN-B's signature, dated October 20, 2021; however, lacked the resident or resident's representative's signature to document agreement on the services to be provided. R3 R3's Individual Service Plan, dated November 2, 2021, indicated R3 received services including, but not limited to, assistance with activities of daily living and medication management. The Individual Service Plan included RN-B's signature, dated October 18, 2021; however, lacked the resident or resident's representative's signature to document agreement on the services to be provided. R7 R7's Individual Service Plan, dated October 28, 2021, indicated R7 received services including, but not limited to, dining services and special diets, dressing/undressing, grooming and hygiene, bathing, ambulation and transfers, communication, memory and orientation, behavior intervention, incontinence care, and	01640		

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01640	Continued From page 14	01640		

medication management. The Individual Service Plan included RN-B's signature, dated August 24, 2021; however, lacked the resident or resident's representative's signature to document agreement on the services to be provided.

R8
R8's Individual Service Plan, dated November 2, 2021, indicated R8 received services including, but not limited to, supervision with dressing, bathing, ambulation, memory and orientation, behavior intervention, incontinence care, and medication management. The Individual Service Plan included RN-B's signature, dated October 22, 2021; however, lacked the resident or resident's representative's signature to document agreement on the services to be provided.

During a telephone interview on November 23, 2021, at approximately 10:15 a.m., LALD-A stated the language in the service plans was changed to include the required content that was lacking during the initial survey, and a new service plan was completed for each resident; however, the new service plans were not sent out to be signed by the resident or their representative.

The licensee's policy, Development and Revision of the Services Plan, dated February 5, 2020, included, "If a review of the service plan indicates that the client's service plan needs modification based on the client's needs, preferences, or changes in fees, the RN, therapist and/or other licensed health professional (as applicable) makes necessary changes to the service plan, signs the revised service plan with name, title and date, and requests that the client and/or the client's representative sign and date the revised service plan."

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01640	Continued From page 15 No further information was provided.	01640		
{01650} SS=C	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included	{01650}		

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{01650}	Continued From page 16	{01650}		

Continued From page 16

the required content for five of five residents (R1, R2, R3, R7, and 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

During the follow up survey entrance conference on November 22, 2021, at approximately 12:10 p.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B indicated the service plan for all residents had been updated to include all of the required content, and all residents had resigned the updated service plan.

R1, R2, R3, R7, and R8's service plans lacked the following:
- schedule and method of monitoring assessments of the resident; and
- methods of monitoring staff providing services.

R1
R1's Individual Service Plan, dated November 2, 2021, indicated R1's services included dining and special diets, assistance with dressing, grooming, bathing, ambulation, mobility, transfer, communication, memory and orientation, continence and toileting, instrumental activities of daily living, and medication administration. The Individual Service Plan lacked the required content noted above.

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{01650}	Continued From page 17 R2 R2's Individual Service Plan, dated November 2, 2021, indicated R2 received services including, but not limited to, assistance with grooming, hygiene, bathing, transfers, and medication management. The Individual Service Plan lacked the required content noted above. R3 R3's Individual Service Plan, dated November 2, 2021, indicated R3 received services including, but not limited to, assistance with activities of daily living and medication management. The Individual Service Plan lacked the required content noted above. R7 R7's Individual Service Plan, dated October 28, 2021, indicated R7 received services including, but not limited to, dining services and special diets, dressing/undressing, grooming and hygiene, bathing, ambulation and transfers, communication, memory and orientation, behavior intervention, incontinence care, and medication management. The Individual Service Plan lacked the required content noted above. R8 R8's Individual Service Plan, dated November 2, 2021, indicated R8 received services including, but not limited to, supervision with dressing, bathing, ambulation, memory and orientation, behavior intervention, incontinence care, and medication management. The Individual Service Plan lacked the required content noted above. On November 22, 2021, at approximately 3:30 p.m., registered nurse (RN)-B stated the language had been changed on the Individual Service Plan to include the above content,	{01650}		

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{01650}	Continued From page 18 however, stated it must have been deleted somehow with revisions that were made. RN-B verified the content was still missing, and stated the template was the same for all residents. The licensee's Contents of Service Plans policy dated January 31, 2020, noted the service plan would include, but not limited to, the schedule and methods of monitoring reviews or reassessments of the resident, the frequency of supervision of staff providing services, and the identification of the supervisor(s) who will be providing the supervision; however, lacked direction to include the method of monitoring the staff providing services. No further information was provided.	{01650}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 12, 2021

Administrator
Rosewood Senior Living LLC
801 Main Street North
Cambridge, MN 55008

RE: Project Number(s) SL27286015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 10, 2021, 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 Home Care 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 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), immediate fine imposition is authorized for both surveys and investigations conducted. 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

The total amount you are assessed is $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. 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

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

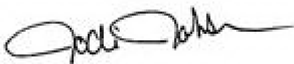
REQUESTING A HEARING

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, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. 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,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 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
	27286	A. BUILDING: ______ B. WING ______	09/10/2021

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ROSEWOOD SENIOR LIVING LLC	801 MAIN STREET NORTH CAMBRIDGE, MN 55008

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a survey investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL# 27286015 On September 8, 2021 through September 10, 2021, 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 26 residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care 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 SUBDIVISION 1-3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions	0 250		

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0 250	Continued From page 1 (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 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;	0 250		

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0 250	Continued From page 2 (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 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 8, 2021, at approximately 10:10 a.m., assisted living director (ALD)-A stated she reviewed the regulations on-line.	0 250		

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0 250	Continued From page 3 The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window). - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I	0 250		

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0 250	Continued From page 4 understand that information submitted to the commissioner in this application may, ins some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in	0 250		

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new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable.
Page five was electronically signed by the owner - ALD-A on May 24, 2021.

The licensee had an assisted living license issued on July 6, 2021, with an expiration date of July 31, 2022.

The licensee failed to ensure the following policies and procedures were developed and/or implemented:
- requirements in section 626.557, reporting of maltreatment of vulnerable adults;
- orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;
- infection control practices;
- reminders for treatments;
- conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards;
- medication and treatment management; and
- supervision of unlicensed personnel performing delegated tasks.

During the entrance conference on September 8, 2021, at approximately 10:10 a.m., registered nurse (RN)-B stated the licensee provided treatment management services.

On September 9, 2021, at approximately 11:10 a.m. ALD-A confirmed the licensee provided treatment reminders, but lacked a policy.

Refer to licensing order at Statute 144G.42,

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0 250	Continued From page 6 Subd. 6(a). The licensee failed to ensure an individual abuse prevention plan was developed to include the required content for three of three residents (R1, R2 and R3) with records reviewed. In addition, the facility failed to investigate incident involving a bedrail for R1. Refer to licensing order at Statute 144G.61, Subd. 2(a). The licensee failed to ensure training and competency evaluations were completed as required, prior to providing direct care, for one of two unlicensed personnel (ULP-E) with records reviewed. Refer to licensing order at Statute 144G.61, Subd. 2(b). The licensee failed to ensure training and competency evaluations were completed as required, prior to providing direct care, for one of two unlicensed personnel (ULP-E) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure four of four employees (ALD-A, RN-B, ULP-D and ULP-E) received orientation to assisted living facility licensing requirements and regulations with records reviewed. Refer to licensing order at Statute 144G.64. The licensee failed to ensure one of four employees (ULP-E) received the required amount of dementia care training, in the required time frame in accordance with 144G.64 with records reviewed. Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current	0 250		

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recommendations for COVID-19.

Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment, documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for three of four employees (ALD-A, ULP-D, and ULP-E) with records reviewed.

Refer to licensing order at Statute 144G.71, Subd. 5. The licensee failed to develop an individualized medication management record with the required content for three of three residents (R1, R2 and R3) with records reviewed.

Refer to licensing order at Statute 144G.71, Subd. 8. The licensee failed to ensure medication was administered as prescribed for two of seven residents (R5 and R6) with records reviewed. In addition, the licensee failed to ensure prescriber orders were transcribed as ordered for one of three residents (R2) with records reviewed.

Refer to licensing order at Statute 144G.72, Subd. 2. The licensee failed to develop, implement and maintain up-to-date written treatment or therapy management policies and procedures with records reviewed.

Refer to licensing order at Statute 144G.91, Subd. 4. The licensee failed to ensure the care and services were provided according to a suitable, and up-to-date plan, and subject to

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0 250	Continued From page 8 acceptable health care and medical, or nursing standards for two of two residents (R1 and R2) with bedrails with records reviewed. Refer to licensing order at Statute 144G.62, Subd. 4. The licensee failed to ensure supervision of unlicensed staff was conducted as required for one of two unlicensed personnel (ULP-D) with records reviewed. Twenty-five (25) correction orders were issued, which indicated 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 was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet 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,	0 470		

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0 470	Continued From page 9 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, interview, and record review, the licensee failed to ensure the required staffing plan was developed and posted as required, potentially affecting all of the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Staff posting The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and	0 470		

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0 470	Continued From page 10 - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On September 8, 2021, at approximately 10:00 a.m. upon arriving at the establishment, the surveyor observed the main entry area and the resident common areas on the main and upper levels; there was no required posting of the staff schedule observed. On September 8, 2021, at approximately 10:55 a.m. during a facility tour with assisted living director (ALD)-A and registered nurse (RN)-B, ALD-A stated everyone entered the facility at the front entrance, and confirmed a staffing schedule had not been posted as required because she was attempting to purchase a telecommunicator; however, it was very expensive. Staffing Plan The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured 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 - ensured 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. On September 9, 2021, at 11:00 a.m., ALD-A stated began working on the staffing plan, but had not completed it yet. ALD-A stated she	0 470		

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0 470

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thought they just had to show proof it was being worked on.

On September 10, 2021, at approximately 10:45 a.m., co-owner-F stated she had started working on the staffing plan. They began with care plans from the county case managers. Co-owner F stated they used the AL (assisted living) Resident Staffing Requirements - All Residents model report based on the cost summary and minimum paid for each resident. The end of the report showed the hours per month that they can spend of each service. The hours are totaled and split between the three shifts as needed. All resident contracts were redone and looked at for the staffing needs. They believe they have the right number of staff, and are looking at the workloads to see what can be moved to another shift as needed. They have taken this report to analyze and determine if they need to adjust the hours. The call light logs have been reviewed to see if the resident calls are being answered timely. Co-owner F stated they are in the process of developing the staffing plan as noted, but do not have this written, other than the staffing requirements report referenced above.

The licensee lacked a policy to include the requirement to post a daily staffing schedule.

No further information was provided.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days

0 510 SS=F

144G.41 Subd. 3 Infection control program

(a) All assisted living facilities must establish and maintain an infection control program that

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0 510	Continued From page 12	0 510		

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 effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This deficient practice had the potential to affect all of the licensee's current residents, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive 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 September 8, 2021, at approximately 11:17 a.m. during a facility tour with assisted living director (ALD)-A and registered nurse (RN)-B, the kitchen manager (KM)-G was observed in the commercial kitchen while working with another staff wearing a cloth bandana covering his nose

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and mouth, instead of wearing a medical-grade mask as required.

On September 9, 2021, at approximately 8:00 a.m., KM-G was observed in the first floor dining area passing plates. Six residents were observed in the dining area at this time. KM-G was observed wearing a bandana covering his nose and mouth.

On September 9, 2021, at approximately 8:35 a.m., KM-G was observed in the second floor dining area passing plates. Six residents were observed in the dining area. At 8:40 a.m., KM-G was observed entering a resident's room with licensed practical nurse (LPN)-C delivering the resident's breakfast. KM-G was observed wearing a bandana covering his nose and mouth.

On September 9, 2021, at approximately 9:35 a.m., ALD-A stated KM-G was in the kitchen, not with residents, so he would not need a medical grade mask. When informed KM-G was observed in dining areas with residents, ALD-A stated all staff were supposed to wear medical-grade masks when in areas with residents.

The licensee's COVID-19 policy, dated August 1, 2020, indicated staff would be screened upon entering for their shift and signs were posted on the doors to guide staff what personal protective equipment (PPE) and precautions were needed with preferred PPE including, but not limited to, face shield or goggles and surgical mask.

The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings document dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative

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0 510	Continued From page 14 residents to wear a medical grade, well-fitting facemask and eye protection. In addition, it instructed HCW with no face-to-face contact with residents to wear a medical-grade, well-fitting facemask. No further information was 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, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all of the licensee's current residents, staff, and	0 550		

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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:

The licensee lacked a posting of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of 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, or any information for reporting suspected maltreatment to MAARC.

On September 8, 2021, during the facility tour at approximately 10:55 a.m., the surveyor observed the entry area and four units' common areas, and noted there was no required posting of the grievance procedure and information related to reporting suspected maltreatment to MAARC.

On September 8, 2021, at approximately 11:00 a.m., assisted living director (ALD)-A confirmed the required content noted above was not currently posted as required.

The licensee's Complaint Policy and Procedure dated January 20, 2020, lacked direction to post the above information as required.

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The licensee's Vulnerable Adult Reporting and Investigation Policy, undated, lacked direction to post the above information as required.

No further information was provided.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days

0 630 SS=E — 144G.42 Subd. 6 Compliance with requirements for reporting ma — 0 630

(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 ensure an individual abuse prevention plan was developed to include 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited

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number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R1, R2, and R3's records lacked an individualized abuse prevention plan to include all areas of vulnerability, as well as specific measures to minimize the risk of abuse to the residents.

R1
On September 9, 2021, at approximately 3:40 p.m., R1 was observed in her room seated in a manual wheelchair, resting with her eyes closed.

R1's Individual Abuse Prevention Plan (IAPP) dated April 15, 2021, indicated R1 did not have community orientation skills, and had an inability to care for self-help needs requiring staff assistance with activities of daily living (ADLs) daily. The assessment lacked identification of being a fall risk as a vulnerability.

R1's Individual Service Plan dated July 6, 2021, indicated R1 could not climb stairs, was unstable on her feet, was unable to discern and/or avoid situations in which she may be in danger, and was considered a high fall risk due to a history of falls, impaired gait, and forgetting her limitations.

An Incident Reporting Form dated August 5, 2021, indicated R1 had an unwitnessed fall at 12:00 p.m. and was found in the living room on her stomach. R1 was transferred with a mechanical lift to the wheelchair and then into bed with no injuries noted. Fall interventions indicated staff were to closely monitor R1 when sitting in the recliner.

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0 630	Continued From page 18	0 630		

On September 10, 2021, at approximately 1:39 p.m. registered nurse (RN)-B confirmed R1 was at risk for falls and that R1's IAPP did not include this information. In addition, RN-B stated the IAPP had not been updated after R1's falls.

R2
On September 9, 2021, at 10:25 a.m., R2 was observed sitting in the wheelchair in his room watching television.

R2's IAPP dated April 29, 2021, identified R2's vulnerabilities including inappropriate interactions with others and verbally/physically abusive to others with specific measures to minimize the risk of abuse; however, the plan failed to identify R2 was a high risk for falls.

R2's Individual Service Plan dated July 29, 2021, indicated R2 received services including, but not limited to, assistance with grooming, hygiene, bathing, transfers, and medication management. The plan also indicated R2 was a high fall risk. In addition, R2's 90-day evaluation dated July 29, 2021, indicated R2 was a high fall risk, due to a history of falls.

On September 9, 2021, at approximately 1:50 p.m. RN-B confirmed R2 was a high fall risk and stated the fall risk should be identified on the IAPP under the lack of self preservation.

R3
R3's IAPP dated February 3, 2021, identified R3's vulnerabilities included the inability to care for self-help needs and the inability to handle financial matters; however, the plan failed to identify R3 was a high fall risk.

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0 630	Continued From page 19 R3's Individual Service Plan dated July 26, 2021, indicated R3 received services including, but not limited to, assistance with activities of daily living and medication management. The plan also indicated R3 was a high risk for falls. On September 9, 2021, at approximately 1:15 p.m. RN-B confirmed R3 was a high risk for falls, and verified the fall risk should be on the IAPP. The licensee's Individual Abuse Prevention Plans policy, undated, included assisted living residents who received nursing services would have an individual abuse prevention plan based on the nursing assessment, which would include an individualized review or assessment of the resident's susceptibility to be abused by another individual, the resident's risk of abusing other vulnerable adults, specific measures to minimize the risk of abuse to that person and other vulnerable adults, and measures to minimize the risk of self-abuse, if applicable. The policy also indicated abuse prevention plans would be completed by day 14 of an initial assessment, reviewed every 90 days, and revised as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:	0 640		

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0 640	Continued From page 20 (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all of the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility; and - post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557.	0 640		

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On September 8, 2021, during the facility tour at approximately 10:55 a.m., the surveyor observed the facility entry area and four units' common areas and noted a sign posted in common areas to call the assisted living director (ALD)-A in the event of an emergency with her phone number listed; however, there was no required posting as noted above.

On September 8, 2021, at approximately 11:00 a.m., ALD-A confirmed the required content was not posted as required. ALD-A stated she preferred to have the staff call her, and she would determine if 911 should be called.

The licensee's Emergency Procedure/911 Calls policy dated January 20, 2020, directed staff discovering an emergency should immediately call the registered nurse or licensed practical nurse onsite. If no nurse was immediately available onsite, staff should promptly call 911. The policy lacked direction to post the 911 emergency number in common areas and near telephones.

No further information was provided.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days

0 650 SS=B	144G.42 Subd. 8 Employee records	0 650		

(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:
(1) evidence of current professional licensure,

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0 650	Continued From page 22 registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of four employees (assisted living director (ALD)-A and unlicensed personnel (ULP)-E) 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 pattern scope (when more than a limited number	0 650		

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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:

ALD-A had a start date of August 1, 2021.

ALD-A's record lacked evidence of a job description, including qualifications, responsibilities, and identification of staff persons providing supervision.

ULP-E had a start date of August 1, 2021.

ULP-E's record contained a job description titled housekeeper; however, ULP-E's employee record lacked evidence of a current job description, including qualifications, responsibilities, and identification of staff persons providing supervision.

On September 10, 2021, at approximately 12:05 p.m. office administrator (OA)-I confirmed the above employee records lacked a current job description with the required content.

The licensee's Personnel Records policy dated January 20, 2020, noted personnel records would include a job description, including qualifications, responsibilities, and identification of supervisors.

No further information was provided.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days

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0 660	Continued From page 24	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which includes a facility TB risk assessment, documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for three of four employees (assisted living director (ALD)-A, unlicensed personnel (ULP)-D, and ULP-E) 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	0 660		

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0 660	Continued From page 25	0 660		

widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).
The findings include:
During the entrance conference on September 8, 2021, at approximately 10:10 a.m. with ALD-A and registered nurse (RN)-B, the sureveyor requested to review the facility TB risk assessment. The undated TB risk assessment provided indicated the licensee was a low risk.

The licensee's employee records lacked evidence of a completed health history and symptom screening, including completion of a two-step TST or other evidence of TB screening, such as a blood test.

ALD-A
ALD-A had a start date of August 1, 2021.

The employee's record lacked evidence of the following:
- TB history and symptom screening; and
- two-step TST or blood test

On September 10, 2021, at approximately 11:55 a.m. office administrator (OA)-I confirmed the required content was not in ALD-A's record and would check the overflow; however, no further documentation was provided.

ULP-D
ULP-D had a start date of August 1, 2021.

The employee's record lacked evidence of the following:
- two-step TST or blood test

ULP-D's record indicated ULP-D had received a

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0 660	Continued From page 26	0 660		

TST on March 2, 2020, but it lacked evidence of a second TST as required.

ULP-E
ULP-E had a start date of August 1, 2021.

The employee's record lacked evidence of the following:
- two-step TST or blood test

ULP-E's record indicated ULP-E had received a TST on August 4, 2020, but it lacked evidence of a second TST as required.

On September 10, 2021, at approximately 12:05 p.m., RN-B confirmed ULP-D and ULP-E's records contained only one TST, and stated she was unaware of the requirement for a two-step TST.

The licensee's TB Prevention and Control policy dated August 10, 2021, noted the second step of the two-step TST is to be completed 7 to 21 days after the first TST is read. The policy also noted the RN would review TB symptoms with each new employee prior to contact with a resident.

The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients.

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0 660	Continued From page 27 Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding 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	0 680		

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0 680	Continued From page 28 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 affect all residents receiving services under the assisted living license, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 8, 2021, at approximately 10:29 a.m., the surveyors conducted a facility tour with the assisted living director (ALD)-A and registered nurse (RN)-B. The facility's layout included one building with residents located on the main and second level in two separate areas on each level, connected by a common sitting area. There was no evidence of signage posted or information regarding the licensee's emergency plan; however, each level had one "flip card" hanging on a plastic hook above the sink in the dining area that directed staff in emergency situations, including, but not limited to, bomb threat, weather, and fire emergencies. A sign posted on stairwell doors directed staff to call the ALD-A, with her phone number posted, for emergencies. Emergency exit diagrams were posted on each floor, and emergency exit diagrams were posted	0 680		

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in each resident's room.

The licensee's plan provided to the surveyors included a Hazard and Vulnerability Assessment Tool, undated, which identified 10 events (such as wildfire, tornado, blizzard) and scored each event based on probability, risk, and severity. No other information was provided.

On September 9, 2021, at 10:10 a.m., ALD-A stated the emergency plan was being worked on by ALD-H, and provided her phone number for a telephone interview.

On September 10, 2021, at 8:33 a.m., ALD-A stated the "flip card" was used to direct staff in an emergency; however, stated it was not posted in a prominent location as required because staff had to reach up and over the sink to pull it off the hook attached to the wall.

During a telephone interview on September 10, 2021, at 9:36 a.m., ALD-H stated she was in charge of developing the Emergency Preparedness (EP) plan, and was working to complete the plan. ALD-H stated she had talked to the health care coalition and applied for membership, reached out to the county's EP staff, the chief of police had toured the building and gave suggestions, and a "go bag" had been prepared with necessities. ALD-H stated she had downloaded information, but had not put it all together yet. ALD-H further verified they had not fully developed and implemented the facility's emergency preparedness plan/program.

The licensee's Plans For Natural Disasters and Emergencies dated January 20, 2021, noted the licensee would have a written plan of action to facilitate the resident's care and services in

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0 680	Continued From page 30 response to a natural disaster or another type of emergency that could affect the ability to provide services. The policy indicated the requirements include having a written disaster plan as described above, emergency and disaster training to all staff during the initial orientation and annually thereafter, and conducting and documenting emergency drills at least every six months, coordinated to the extent possible with local fire departments or other community emergency resources. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide and maintain the building physical environment including walls, floors, ceiling, furnishings, equipment including air handling system in a continuous state of good repair and operation for health, comfort, and well-being of residents in accordance with a maintenance and repair program. This has the potential to directly affect all residents and staff.	0 800		

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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:

On September 8, 2021, at 1:15 p.m., survey staff began the facility tour with the housing manager and assisted living director (ALD)-A, and all of the findings were verified during the tour.
1. Bathroom exhaust fan covers throughout facility were dusty.
2. Exhaust fan covers for bathroom #113 and the half bath on the second floor were not secured.
3. Paint near shower head in bathroom #115 was peeling from water leakage/damage, and had the potential for mold growth over time.
4. Flooring in small kitchen on first floor had some uneven surfaces due to previous refrigerator leakage. The housing manager explained the old refrigerator had a water leak. A new refrigerator had been installed over a month ago. ALD-A stated they were in the process of replacing the flooring in kitchen, along with other areas of the first floor.
5. Flooring transition strips were damaged in Room 107, creating sharp edges and tripping hazards.
6. Chemicals, such as Lysol cleaning products, were found located and accessible by all residents to use in bathrooms, which has the potential to create an unsafe environment for

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ROSEWOOD SENIOR LIVING LLC	801 MAIN STREET NORTH CAMBRIDGE, MN 55008

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0 800		0 800		

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misuse by the residents.
7. The light bulb providing lighting at the end of corridor of the basement near the offices was not working.
8. The water softener located in the sprinkler riser room was installed with the backwash discharge line submerged into a sewer cleanout with a chipped opening on top of the cover. The improper installation poses both a cross connection in the potable water system and allows sewer gas to enter the building environment creating an unsafe and health risks to residents and employees. All corrections must be performed by a Minnesota licensed plumbing contractor per Minn. Statutes 326b.46, and must be approved and inspected by the administrative authority for compliance with the Minnesota Plumbing Code.
9. The water line serving the chemical soap dispenser from the mop sink faucet was not protected with proper backflow preventer, creating a risk of backflow of chemicals into the potable water supply. All corrections must be performed by a Minnesota licensed plumbing contractor per Minn. Statutes 426b.46, and must be approved and inspected by the administrative authority for compliance with the Minnesota Plumbing Code.

The licensee's Resident Agreement for Rosewood Senior Living, dated July 28, 2021, under 17. "Our responsibilities for the facilities, we promise: A. that the room and all common areas are fit for use as residential premises; B. The keep the room and all common areas in reasonable repair during the term of the Agreement, except when the disrepair has been caused by the willful or negligent conduct of your or your guests; C. To maintain the room and all common areas in compliance with the applicable

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0 800	Continued From page 33 health and safety laws, except when violation of the health and safety laws has been caused by the willful or negligent conduct of your or your guests; D. To maintain the common areas in a state of repair and cleanliness; E. to make repairs to the room as necessary." This document was signed and dated by resident (R1)'s representative and ALD-A on July 30, 2021, R3's representative and ALD-A on August 2, 2021, and R2 and ALD-A on August 27, 2021. No further information was provided. 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 (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. (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.	0 810		

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0 810	Continued From page 34 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide the required staff training and records for fire safety and evacuations as required. This has the potential to directly affect the safety of all residents and staff. 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: On September 8, 2021, at 1:15 p.m., survey staff toured the facility with the assisted living director (ALD)-A. At approximately 1:55 p.m., the housing manager replaced ALD-A for the remaining of the facility tour. The facility fire safety and evacuation plan documentation was requested and was noted to lack the following:	0 810		

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0 810	Continued From page 35 1. Documentation of required employee evacuation drills. 2. The schedule and required records on training of employees on fire safety and evacuation. 3. The schedule and required records on training of residents who are capable of assisting their own evacuation on proper actions to take in the event of a fire for their safety including movement, evacuation, or relocation. Employees and residents who are capable of assisting their own evacuation must be trained on fire safety and evacuation plans and procedures. Fire safety and evacuation plans must be readily available at all times within the facility. Employees are required to complete evacuation drills. Failure to provide these plans, training and drills can cause confusion and delay response time for evacuation of residents and employees. On September 8, 2021, at approximately 3:30 p.m. ALD-A was not able to provide the information listed above as requested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of:	0 900		

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(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.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for two of four residents (R2 and R3) with records reviewed. In addition, the licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its' contract.

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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:

The licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete, unsigned copy of its' contract as required.

On September 10, 2021, at approximately 11:10 a.m. assisted living director (ALD)-A confirmed a complete, unsigned copy of the licensee's contract had not been sent to the Ombudsman as required.

R2
On September 9, 2021, at 10:25 a.m., R2 was observed sitting in the wheelchair in his room watching television.

R2's Individual Service Plan, dated July 29, 2021, indicated R2 received services including, but not limited to, assistance with grooming and hygiene, bathing, transfers, and medication management. The plan also indicated R2 was a high risk for falls.

R2's record contained a Resident Agreement dated August 27, 2021, which was 27 days after R2 began receiving services under the assisted living facility license.

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On September 9, 2021, at approximately 11:17 a.m., ALD-A stated R2 had refused to sign the contract prior to August 27, 2021, and further verified R2's record contained no documentation of the refusal.

R3
R3's Individual Service Plan, dated July 26, 2021, indicated R3 received services including, but not limited to, assistance with activities of daily living and medication management. The plan also indicated R3 was a high risk for falls.

R3's record contained a Resident Agreement dated August 2, 2021, which was two days after R3 began receiving services under the assisted living facility license.

On September 9, 2021, at approximately 11:15 a.m., ALD-A confirmed R3's daughter was not able to come to sign the contract until August 2, 2021, and stated R3's record contained no documentation of the delay.

The licensee's Content of Home Care Services Agreement policy dated January 20, 2020, noted each home care client/representative would execute and update as needed, an agreement that identified the business terms of the relationship between the licensee and the client. In addition, the policy noted the agreement would be signed by the registered nurse and the client/representative.

No further information was provided.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days

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01370	Continued From page 39	01370		
01370 SS=D	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; (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	01370		

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01370	Continued From page 40 emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E's employee record lacked evidence to indicate the employee completed training and/or practical skills evaluations as required in the following area: - understanding appropriate boundaries between staff and residents and the resident's family. ULP-E had a start date of August 1, 2021. On September 9, 2021, from approximately 8:00 a.m. through 8:30 a.m., ULP-E was observed administering medications to multiple residents at breakfast time. ULP-E's employee's record contained a	01370		

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01370	Continued From page 41	01370		

Delegated Duties Class 2021 form dated July 15, 2021, which listed numerous training and demonstration topics; however, the form lacked information related to the above required training.

On September 10, 2021, at approximately 12:05 p.m., office administrator (OA)-I verified the form lacked the required content noted above.

The licensee's Training and Competency Evaluation of Unlicensed Staff policy, dated January 24, 2020, noted required content for ULP training included understanding appropriate boundaries between staff and clients [residents] and families.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

01380 SS=D — 144G.61 Subd. 2 Training and evaluation of unlicensed personn — 01380

(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

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01380	Continued From page 42 (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care to residents for one of two unlicensed personnel (ULP)-E with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E's employee record lacked evidence to indicate the employee had completed training and/or practical skills evaluations as required in the following area: - recognizing physical, emotional, cognitive, and developmental needs of the resident ULP-E had a start date of August 1, 2021. On September 9, 2021, from approximately 8:00 a.m. through 8:30 a.m., ULP-E was observed administering medications to multiple residents at breakfast time. ULP-E's employee record contained a Delegated Duties Class 2021 form, dated July 15, 2021,	01380		

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01380	Continued From page 43 which listed numerous training and demonstration topics; however, the form lacked information related to the above required training. On September 10, 2021, at approximately 12:05 p.m., office administrator (OA)-I verified the form lacked the required content noted above. The licensee's Training and Competency Evaluation of Unlicensed Staff policy, dated January 24, 2020, indicated required content for ULP training included recognizing physical, emotional, cognitive, and developmental needs of the client [resident]. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01380		
01440 SS=D	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	01440		

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01440	Continued From page 44 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 a registered nurse (RN) conducted supervision of unlicensed staff as required for one of two unlicensed personnel (ULP)-D with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D began providing assisted living services for the licensee's residents on August 1, 2021. The employee's records lacked evidence an RN conducted direct supervision of ULP-D within 30 days of performing delegated tasks. On September 8, 2021, at approximately 11:09 a.m., ULP-D was observed administering eye drops to resident (R5). ULP-D's employee record contained Notes on Supervision of Unlicensed Personnel, dated April 27, 2020, which was 72 days after she began providing delegated tasks under the licensee's	01440		

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01440	Continued From page 45 former comprehensive home care license. There was no further evidence RN supervision had occurred. On September 10, 2021, at approximately 12:13 p.m., RN-B stated she conducted supervision of ULPs performing delegated tasks as soon as she was made aware that supervision needed to be completed. RN-B verified the supervision for ULP-D did not occur within 30 days of performing delegated tasks as required. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated January 20, 2020, noted direct supervision of a ULP by an RN would be completed within 30 calendar days after the ULP began working and first performed delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting	01470		

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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
01470	Continued From page 46 Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01470		

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assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure four of four employees, assisted living director (ALD)-A, registered nurse (RN)-B, unlicensed personnel (ULP)-D, and ULP-E received orientation to assisted living facility licensing requirements and regulations 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:

ALD-A, RN-B, ULP-D and ULP-E's employee records lacked evidence to indicate the employees had received orientation to include the required topics.

On September 9, 2021, at approximately 11:10 a.m., ALD-A indicated staff had not been trained on all of the new policies and procedures because some of the policies had not been completed or approved by the licensee's owners.

ALD-A, RN-B, ULP-D and ULP-E all began providing assisted living services for the licensee on August 1, 2021.

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01470	Continued From page 48 ALD-A ALD-A's record lacked: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On September 10, 2021, at approximately 11:55 a.m., office administrator (OA)-I confirmed ALD-A had not completed the required orientation noted above. RN-B RN-B's record lacked: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On September 10, 2021, at approximately 11:50 a.m., OA-I confirmed RN-B had not completed the required orientation noted above. ULP-D ULP-D's record lacked: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and - a review of the types of assisted living services	01470		

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01470	Continued From page 49 the employee will be providing and the facility's category of licensure. On September 10, 2021, at approximately 11:50 a.m., OA-I confirmed ULP-D had not completed the required orientation noted above. ULP-E ULP-E's record lacked: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	01470		

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On September 9, 2021, from approximately 8:00 a.m. through 8:30 a.m., ULP-E was observed administering medications to multiple residents at breakfast time.

On September 10, 2021, at approximately 12:00 p.m., OA-I confirmed all of the employees noted above had not completed the required orientation.

The licensee's Home Care Orientation policy dated January 22, 2020, noted direct care staff must complete orientation to home care prior to providing services, and the orientation would include:
- an overview of Minnesota's home care law;
- an introduction and review of the facility's policies and procedures related to the provision of home care services;
- handling of emergencies and use of emergency services;
- reporting the maltreatment of vulnerable adults under section 626.556 and 626.557;
- the home care bill of rights;
- system for receiving and responding to complaints, where to report complaints and information on the Office of Health Facility Complaints and the Common Entry Point and how clients, staff and others may contact these agencies with complaints;
- consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and
- a review of the types of home care services the employee will be providing and scope of licensure.

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01470	Continued From page 51 The policy did not include the current assisted living licensure requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
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 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	01530		

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by:
Based on observation, interview and record review, the licensee failed to ensure one of four employees, unlicensed personnel (ULP)-E received the required amount of dementia care training, in the required time frame in accordance with 144G.64 with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

The licensee provided services under an assisted living license. The licensee's website indicated services included memory care.

During the entrance conference on September 8, 2021, at approximately 10:10 a.m., assisted living director (ALD)-A and registered nurse (RN)-B stated the licensee had residents with the diagnosis of dementia, but had no special care unit or program.

ULP-E had a start date of August 1, 2021.

ULP-E's employee record contained evidence ULP-E had received 3.5 hours dementia related training, but lacked the required eight (8) hours of initial training.

On September 9, 2021, from approximately 8:00 a.m. through 8:30 a.m., ULP-E was observed

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01530	Continued From page 53 administering medications to multiple residents at breakfast time. On September 10, 2021, at approximately 12:05 p.m., office administrator (OA)-I verified ULP-E had not received the required amount of dementia related training. The licensee's Dementia Care Training For Home Care Employees/Staff providing Home Care Services in Housing with Services Establishments with Dementia Programs and/or Assisted Living Services policy, undated, noted direct-care staff hired after January 1, 2016, would complete at least four hours of initial training within 160 working hours. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01530		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	01650		

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(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 observation, interview, and record review, the licensee failed to ensure the service plan included 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 the potential to affect a large portion or all of the residents).

The findings include:

R1, R2 and R3's service plans lacked the following:
- schedule and method of monitoring assessments of the resident;
- schedule and methods of monitoring staff

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providing services; and
- a contingency plan that included:
  - the action to be taken if the scheduled service cannot be provided.

R1
On September 9, 2021, at approximately 3:40 p.m., R1 was observed in her room seated in a manual wheelchair resting with her eyes closed.

R1's Individual Service Plan dated July 5, 2021, indicated R1's services included dining and special diets, assistance with dressing, grooming, bathing, ambulation, mobility, transfer, communication, memory and orientation, continence and toileting, instrumental activities of daily living, and medication administration.

R1's Resident Agreement dated July 30, 2021, identified as part of the service plan, lacked the required content noted above.

R2
On September 9, 2021, at 10:25 a.m., R2 was observed sitting in the wheelchair in his room watching television.

R2's Individual Service Plan dated July 29, 2021, indicated R2 received services including, but not limited to, assistance with grooming, hygiene, bathing, transfers, and medication management.

R2's Resident Agreement dated August 27, 2021, identified as a part of the service plan, lacked the required content noted above.

R3
R3's Individual Service Plan dated July 26, 2021, indicated R3 received services including, but not limited to, assistance with activities of daily living

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and medication management.

R3's Resident Agreement dated August 2, 2021, identified as a part of the service plan, lacked the required content noted above.

On September 9, 2021, at approximately 1:30 p.m., co-owner-F confirmed the service plans for all residents lacked the required content noted above.

The licensee's Contents of Service Plans policy dated January 3, 2020, noted the service plan would include, but not limited to, the schedule and methods of monitoring reviews or reassessments of the resident, the frequency of supervision of staff providing services and the identification of the supervisor(s) who will be providing the supervision, and a contingency plan that includes the circumstances in which emergency medical services are not to be summoned pursuant to provider orders related thereto.

No further information was provided.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days.

01730 SS=F | 144G.71 Subd. 5 Individualized medication management plan | 01730

(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for

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01730	Continued From page 57 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 review, the licensee failed to develop an individualized medication management record with the required content for three of three	01730		

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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:
During the entrance conference on September 8, 2021, at approximately 10:17 a.m., assistant living director (ALD)-A indicated the licensee provided medication management services for the licensee's residents.

R1
R1's record lacked a medication management plan to include the following required content:
- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and
- identification of medication management tasks that may be delegated to unlicensed personnel.

R1 began receiving services on March 31, 2021, under the comprehensive home care license with diagnoses that included, but were not limited to, dementia without behavioral disturbances, chronic heart failure, and history of stroke.

On September 9, 2021, at approximately 3:40 p.m., R1 was observed in her room seated in a manual wheelchair resting with her eyes closed.

R1's prescriber orders dated August 23, 2021, included, but were not limited to, a pain reliever,

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an antidepressant, and an antihypertensive.

R1's Individual Service Plan dated July 5, 2021, indicated R1 required staff to administer daily medications due to cognitive impairment.

R1's 90 day assessment dated July 5, 2021, indicated R1 required staff to administer medications due to cognitive impairment and services needed were medication reminders, central storage of medications, medication set-ups, and administration of medications.

On September 10, 2021, at approximately 1:42 p.m., registered nurse (RN)-B verified R1's record lacked a medication management plan with the above required content. RN-B verified R1 did not receive medication reminders or medication set-ups as noted on the 90 day assessment and stated those services should be removed.

R2
R2's record lacked a medication management plan to include:
- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;
- identification of medication management tasks that may be delegated to unlicensed personnel; and
- procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services.

On September 9, 2021, at 10:25 a.m., R2 was observed sitting in the wheelchair in his room watching television.

R2's prescriber orders dated May 27, 2021,

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included, but were not limited to, two insulin medications and one medication to lower blood pressure.

R2's Individual Service Plan dated July 29, 2021, indicated R2 received services including, but not limited to, assistance with grooming, hygiene, bathing, transfers, and medication management.

R2's 90 day evaluation dated July 29, 2021, identified R2 required services to include medication reminders, central storage of medications, mediation set-ups and medication administration.

R2's Resident Agreement dated August 27, 2021, identified as a part of the service plan, lacked the above required content.

R2's Medication Administration Record (MAR) dated September 2021, listed the medications, times to administer, and staff initials to indicate the medications were administered.

On September 9, 2021, at approximately 1:50 p.m., RN-B confirmed R2's assessment incorrectly noted services included medication reminders and medication set-ups. RN-B verified R2's record lacked the above required content.

R3
R3's record lacked a medication management plan to include:
- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;
- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;

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and
- identification of medication management tasks that may be delegated to unlicensed personnel.

R3's prescriber orders dated July 7, 2021, included, but were not limited to, one diuretic (to aid the body to remove salt and water) and one medication to lower blood pressure.

R3's Individual Service Plan dated July 26, 2021, indicated R3 received services including, but not limited to, assistance with activities of daily living and medication management.

R3's 90 day evaluation dated April 26, 2021, indicated R3 required services including medication reminders, central storage of medications, mediation set-ups and medication administration.

R3's Resident Agreement dated August 2, 2021, identified as a part of the service plan, lacked the above required content.

R3's Medication Administration Record (MAR) dated September 2021, listed the medications, times to administer, and staff initials to indicate the medications were administered.

On September 9, 2021, at approximately 1:30 p.m., co-owner-F confirmed the service plans for all residents lacked the above required content.

The licensee's Medication Management Services policy, undated, indicated based on the nursing assessment, the RN would develop an individualized medication management plan for each client receiving any type of medication management services. The policy lacked direction as to what the plan would include.

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01730	Continued From page 62 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for two of seven residents (R5 and R6) with records reviewed. In addition, the licensee failed to ensure prescriber orders were transcribed as ordered for one of three residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01760		

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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:

MEDICATIONS NOT ADMINISTERED AS ORDERED/MEDICATION ERROR

R5 and R6's medications were not administered as prescribed.

R5
R5's diagnoses included, but were not limited to, borderline personality disorder, chronic obstructive pulmonary disorder, and Type 2 diabetes.

R5's prescriber orders dated September 1, 2021, included an order for artificial tears ointment to be administered by placing a strip to each eye at bedtime as needed.

On September 8, 2021, at approximately 11:05 a.m., unlicensed personnel (ULP)-D was observed administering artificial tears ointment, one strip to each eye, to R5. ULP-D returned to the first floor medication cart and displayed the ointment tube, which identified the medication as artificial tears ointment, with directions to apply one strip to each eye at bedtime as needed.

When interviewed on September 8, 2021, at 11:09 a.m., ULP-D stated she administered the artificial tears ointment at this time because R5 always requested it at this time of day. ULP-D's Medication Administration Record (MAR) reviewed with registered nurse (RN)-B for the

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prior 72 hours, lacked evidence of this.

On September 9, 2021, at 2:07 p.m., RN-B indicated the artificial tears ointment was ordered to be administered at bedtime, and verified it was not administered as ordered.

The licensee's Medication Errors policy dated February 17, 2020, indicated the RN would immediately investigate medications errors and would implement and document corrective actions to reduce the risk of similar medication errors in the future.

R6
On September 9, 2021, at approximately 8:00 a.m., ULP-E was observed administering oral medications to R6 in his living area. R6 then took his Combivent aerosol 20-100 inhaler and independently administered 3 puffs in front of ULP-E. Upon returning to the medication cart, ULP-E verified R6 administered 3 puffs versus the prescribed 2 puffs.

R6's Individual Service Plan dated June 25, 2021, indicated services included assistance with ambulation, activities of daily living, and medication management.

R6's prescriber orders dated July 7, 2021, included an order for Combivent aerosol 20-100, inhale 2 puffs orally twice daily.

R6's MAR dated September 2021 lacked identification R6 received 3 puffs as observed on September 9, 2021.

On September 9, 2021, at approximately 11:05 a.m., RN-B confirmed R6 occasionally takes 3 puffs of his inhaler versus the prescribed 2 puffs.

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In addition, RN-B stated this has not been reported to R6's primary physician, and a medication error had not been completed for this.

The Combivent Inhalation Aerosol literature, reference ID: 3176499, revision date August 2012, indicated under warnings "3. Do Not Exceed Recommended Dose: Fatalities have been reported in association with excessive use of inhaled sympathomimetic drugs, in patients with asthma. The exact cause of death is unknown, but cardiac arrest following an unexpected development of a severe acute asthmatic crisis and subsequent hypoxia is suspected."

TRANSCRIPTION OF PRESCRIBER'S ORDERS

R2
R2's prescriber orders dated July 19, 2021, included an order for docusate sodium 100 mg two caps daily and simvastatin 20 mg one tab orally daily.

During an observation on September 9, 2021, at 8:12 a.m., licensed practical nurse (LPN)-C prepared to administer R2's medications. Medication labels were reviewed as LPN-C popped them from pharmacy bubble packs into a medication cup. R2's docusate sodium label directed to give two 100 milligram (mg) caps every evening. LPN-C stated R2 preferred to take the docusate sodium in the morning, and the prescriber order and the time to administer the medication had been changed on the MAR to 8:00 a.m. daily; however, the label on the medication and the directions on the MAR still indicated to give in the evening. In addition, R2's simvastatin label directed to give one 20 mg tab orally once a day at bedtime. LPN-C again stated

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the prescriber order had been changed due to R2's preference to take the medication in the morning; however, the medication label and MAR directions still indicated to give at bedtime.

On September 9, 2021, at 2:05 p.m., RN-B stated transcription of medication orders should match on labels and the MAR.

The licensee's Medication Management Services policy, undated, indicated the RN or LPN would review each resident's medication record at appropriate times based on the resident's needs and their medication management services, to verify that staff was administering the medications as prescribed and documenting administration appropriately.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

01930 SS=F 144G.72 Subd. 2 Policies and procedures 01930

(a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.
(b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting

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treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to develop, implement and maintain up-to-date written treatment or therapy management policies and procedures 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

During the entrance conference on September 8, 2021, at approximately 10:10 a.m., registered nurse (RN)-B stated the licensee provided treatment management services.

The licensee lacked the following required policies:
- documenting treatment or therapy activities; and
- educating and communicating with residents about treatments or therapies they are receiving.

On September 9, 2021, at approximately 2:55 p.m., assisted living director (ALD)-A confirmed the licensee lacked the above required policies

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01930	Continued From page 68 and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for two of two residents (R1 and R2) with side 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: R1 and R2's records lacked evidence the registered nurse (RN) had completed an assessment of the side rails according to the Food and Drug Administration (FDA) guidelines	02310		

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per the licensee's policy.

R1
R1's diagnoses included, but were not limited to, dementia, chronic heart failure, and history of stroke.

R1's Individual Abuse Prevention Plan (IAPP) dated April 15, 2021, indicated R1 had an inability to care for self-help needs and required staff assistance with activities of daily living (ADLs) daily. The assessment lacked any mention R1 had or used side rails.

R1's Individual Service Plan dated July 6, 2021, indicated R1 was able to make movements in bed, but required staff assistance when sitting up. The assessment lacked any mention R1 had or used side rails.

R1's record included a Side-Rail Use Assessment Form dated July 5, 2021, which indicated R1's level of consciousness fluctuated. R1 had an alteration in safety awareness due to cognition, a history of falls, poor bed mobility or difficulty moving to a sitting position on the side of the bed, difficulty with balance or poor trunk control, currently using the side rail for positioning or support, expressed a desire to have side rails raised while in bed for safety and/or comfort, and requested that the side rails not be released while sleeping. The assessment indicated the side rails provided restorative care to enhance abilities to safely stand and walk, were indicated and served as an enabler to promote independence. The assessment indicated the positive and negative aspects of side rail use had been discussed with R1 and/or family, and R1 and/or responsible parties were aware of the risks involved with side rail use. The side rail assessment lacked

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measurements to determine the level of risk for entrapment and steps taken to mitigate the risk.

An Incident Reporting Form dated August 17, 2021, indicated on August 14, 2021, at 3:41 a.m., R1 was calling out "help help." R1 was found lying by the bed with blankets and comforter under her with her left arm stuck in the side rail. The report indicated the writer could not get R1's arm out of the side rail and called 911. While waiting for emergency response, another staff was able to "get the side rail up but resident was still stuck partly under bed and siderail would come up some." The report indicated R1 was "hoyered [lifted with mechanical lift] into bed by writer, paramedic and EMT [emergency medical technician]." R1 was not taken to the hospital per family and paramedic decision. R1 complained of left shoulder pain, but was able to fall back to sleep after the incident; R1's vital signs were within normal limits (WNL). The incident report indicated the left side rail was removed from the bed. The incident report also indicated registered nurse (RN)-B and R1's family were notified of the incident. In addition, the incident report included an Administrator Report completed by RN-B and signed August 17, 2021, which indicated R1 was able to recall the fall and reported that she was having a dream which caused her to roll out of bed; however, R1 denied pain and stated she was fine and "well enough to go back to work." RN-B documented no bruising, redness, or abnormalities. R1's range of motion was per baseline, and it was noted the side rail had been removed from the bed to prevent any further incident.

R1's nurse's note on August 14, 2021, at 6:48 a.m. included at 3:41 a.m., R1 rolled out of bed, RN-B and family were updated, and R1's left

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shoulder felt better per R1; she was able to move her arm and shoulder per normal.

R1's nurse's note on August 17, 2021, at 9:30 a.m. written by RN-B, indicated R1's health had been per baseline with no concerns. The note also read, "Intervention: side rail has been removed from her bed to prevent any further incident."

On September 9, 2021, at approximately 3:40 p.m. R1 was observed in her room seated in a manual wheelchair. Next to the wheelchair was R1's bed equipped with bilateral side rails covering the upper third of R1's mattress, and both were in the raised position. When the surveyor grasped the rail, it moved slightly. There was no gap observed between the rail and the mattress.

On September 9, 2021, at approximately 3:50 p.m. R1 stated she did not use the side rails to turn or stand. R1 stated, "They use them to keep me in bed."

On September 9, 2021, at approximately 4:10 p.m. RN-B indicated staff present at the time of the incident were expected to complete an incident report, notify her and the family, and, "if appropriate," RN-B stated she assesses the resident and puts interventions into place as needed. When asked to describe R1's incident, RN-B indicated it was difficult to understand what occurred because the written description by the staff was confusing; however, RN-B stated she had not interviewed the staff that were caring for R1 that night to clarify what had occurred. RN-B stated the side rails had been removed that night, but were put back on R1's bed in middle to late August 2021, when her family purchased a new

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mattress for the bed. RN-B stated she was not made aware that the side rail was put back on the bed at that time, and stated she would expect the staff to notify her. RN-B verified she had not completed a side rail assessment to ensure the appropriateness of the side rails after R1's fall from the bed or after the placement of the new mattress.

R2
On September 9, 2021, at 10:25 a.m. R2 was observed sitting in the wheelchair in his room watching television. R2's bed was observed with bilateral side rails with no gaps noted to be greater than 4 3/4 inches. R2 stated he does not sleep in his bed typically, and had practiced sleeping in bed once since the side rails were applied. R2 stated he would utilize the side rails to help turn and reposition in bed.

R2's Side-Rail Use Assessment Form dated April 29, 2021, noted the side rails were indicated to promote independence.

R2's Individual Service Plan dated July 29, 2021, indicated R2 received services including, but not limited to, assistance with grooming any hygiene, bathing, transfers, and medication management.

On September 9, 2021, at approximately 1:50 p.m. RN-B confirmed R2's assessment lacked measurements of the side rails and confirmed the licensee's policy noted the assessment would be consistent with the FDA guidelines.

The licensee's Reporting, Documenting, and Reviewing Incidents Involving Clients policy dated January 20, 2020, included whenever there was an incident involving a resident, the staff present would immediately contact the nurse in charge

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and would complete an incident report as soon as possible, and the RN would document the details of any incident in the client's chart and would document the follow-up actions that were taken. In addition, the RN would review the incident report with the home care director, and the RN would complete the review, comment, and follow-up sections of the incident report.

The licensee's Assessing the Safety of Side Rails policy dated January 9, 2020, indicated staff would alert the RN or licensed professional if a resident had any type of side rail or similar equipment and the RN or licensed professional would then evaluate whether the side rail appeared to be safe for the resident and determine whether the side rail/equipment met the Food and Drug Administration (FDA) standards for side rails.

The Food and Drug Administration (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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD SENIOR LIVING LLC	801 MAIN STREET NORTH CAMBRIDGE, MN 55008

(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 74	03090		
03090 SS=F	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, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not 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 finding include: Upon entrance on September 8, 2021, at approximately 10:00 a.m., an observation outside the front entrance and just inside the front entrance showed no required posting for	03090		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27286	A. BUILDING: ______ B. WING ______	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD SENIOR LIVING LLC	**801 MAIN STREET NORTH CAMBRIDGE, MN 55008**

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03090	Continued From page 75 electronic monitoring devices. On September 8, 2021, at approximately 10:29 a.m., during a facility tour of the establishment conducted with assisted living director (ALD)-A and registered nurse (RN)-B, ALD-A stated the door entered from the parking lot was the main door utilized. ALD-A confirmed no posting was available related to the statutory language for electronic monitoring. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/08/21*
Time: 10:30:00
Report: 1025211249

Food and Beverage Establishment Inspection Report

Location:
Rosewood Senior Living
801 Main St NE
Cambridge, MN55008
Isanti County, 30

Establishment Info:
ID #: NCI0001
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 300 PPM at Degrees Fahrenheit
Location: 3 compartment sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: #12 cooler
Violation Issued: No

Process/Item: Ambient
Temperature: 41 Degrees Fahrenheit - Location: #24 cooler
Violation Issued: No

Process/Item: Ambient
Temperature: OK Degrees Fahrenheit - Location: Upright freezer - frozen
Violation Issued: No

Process/Item: Ham, deli
Temperature: 41 Degrees Fahrenheit - Location: Upright cooler, kitchen
Violation Issued: No

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

Discussed employee health and hygiene, handwashing, V/D/fever/wound illness exclusion and recording, handling ready-to-eat foods; no reservice of served food; cooling process, using metal pans and monitoring process using available food thermometer from 135 deg F to 70 in 2 hours, 135 to 41 deg F in six hours total; date marking scheme; food allergens; food source and not using foods from an uninspected source (e.g. home-prepared foods, except for resident personal items, foods sold at community events not

Food and Beverage Establishment Inspection Report

required to be subject to inspection), shipment, and refusing damaged or adulterated items; cooking temperatures; testing sanitizing temperatures and concentrations; W/R/S of food contact surfaces and utensils. Provide cooking, cooling, and hot holding equipment which meets MN 4626.0506; refrigeration in neighborhood kitchens which do not meet this standard are used for resident personal items only; #12 and #24 used for facility food. Reviewed use and service of eggs for highly susceptible populations. Discussed use of fans in the kitchen; direct air flow away from open items and maintain clean to avoid dust. Temperature checks for equipment are logged using charting software.

New dish machine install to be verified by City; not in use and not operating during inspection. Discussed reading gauges, identifying data plate, and routine testing for operation, using the available irreversible temperature indicator (stickers). Verify proper operation before using. Dishes to be washed in serving neighborhood kitchens and returned to kitchen for final sanitizing in dish machine or 3 compartment sink.

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

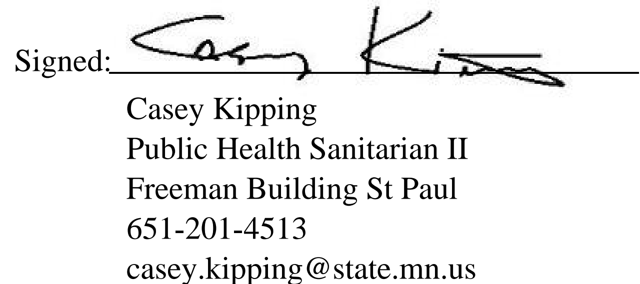
I acknowledge receipt of the Minnesota Department of Health inspection report number 1025211249 of 09/08/21.

Certified Food Protection Manager: Benjamin R Gordenier

Certification Number: FM99200 Expires: 06/11/22

Inspection report reviewed with person in charge and emailed.

Signed: ____________________
Ben

Signed:


Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025211249

Food Establishment Inspection Report

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	09/08/21
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

Establishment	Address	City/State	Zip Code	Telephone
Rosewood Senior Living	801 Main St NE	Cambridge, MN	55008	

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
NCI0001		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

#	Compliance Status (circled)	Item	COS	R
	Supervision			
1	IN	PIC knowledgeable; duties & oversight		
2	IN	Certified food protection manager, duties		
	Employee Health			
3	IN	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN	Proper use of reporting, restriction & exclusion		
5	IN	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN	Proper eating, tasting, drinking, or tobacco use		
7	IN	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean & properly washed		
9	IN	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food received at proper temperature		
13	IN	Food in good condition, safe, & unadulterated		
14	N/A	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN	Food separated and protected		
16	IN	Food contact surfaces: cleaned & sanitized		
17	IN	Proper disposition of returned, previously served, reconditioned, & unsafe food		
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperature		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time & temperature		
21	N/O	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as a public health control: procedures & records		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	N/A	Food additives: approved & properly used		
28	IN	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance/specialized process/HACCP		

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

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.
Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

#	Mark	Item	COS	R
	Safe Food and Water			
30	IN	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	N/A	Variance obtained for specialized processing methods		
	Food Temperature Control			
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
	Food Identification			
37		Food properly labled; original container		
	Prevention of Food Contamination			
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		
	Proper Use of Utensils			
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
	Utensil Equipment and Vending			
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
	Physical Facilities			
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 09/15/21

Inspector (Signature) [signature]

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/08/21*
Time: 10:30:00
Report: 1025211249

Food and Beverage Establishment Inspection Report

Location:
Rosewood Senior Living
801 Main St NE
Cambridge, MN55008
Isanti County, 30

Establishment Info:
ID #: NCI0001
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
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Food and Beverage Establishment Inspection Report

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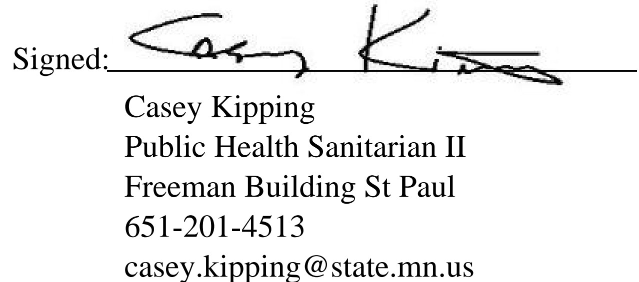

Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025211249

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0
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Legal Authority MN Rules Chapter 4626	

Date 09/08/21
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58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 09/15/21

Inspector (Signature) [signature]