Electronically Delivered

February 7, 2023

Licensee
The Wealshire Of Bloomington
10601 Lyndale Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL30803015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 7, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

**DOCUMENTATION OF ACTION TO COMPLY**
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's

resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

**CORRECTION ORDER RECONSIDERATION PROCESS**
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
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Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 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 |
|---|---|---|---|
| | 30803 | A. BUILDING: _____ B. WING _____ | 12/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WEALSHIRE OF BLOOMINGTON | 10601 LYNDALE AVENUE SOUTH BLOOMINGTON, MN 55420 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>SL30803015-0<br><br>On, December 5, 2022 through December 7, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey there were 94 residents, all of whom received services under the provider's Assisted Living with Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care license providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 5, 2022, for the specific Minnesota Food Code deficiencies. | 0 480 | | |

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| 0 480 | Continued From page 2<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing tenant residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan (EP) with all the | 0 680 | | |

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| 0 680 | Continued From page 3<br>required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all staff, visitors, and residents receiving services under the license.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).<br><br>The findings include:<br><br>The licensee lacked evidence of the following required content:<br>- a comprehensive program to include infectious diseases and pandemics;<br>- a description of the population served by the licensee;<br>- procedure for tracking staff and residents;<br>- subsistence needs for staff and residents during emergency situation;<br>- development of policies/procedures to address:<br>- evacuation plan (not customized for the facility);<br>- fire (not customized for the facility);<br>- shelter in place;<br>- a tracking system used to document locations or residents and staff;<br>- the medical record documentation system to preserve resident information;<br>- emergency staff strategies; and<br>- the facilities role in providing care and treatment at alternative sites; management agencies;<br>- a method of sharing information and | 0 680 | | |

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| 0 680 | Continued From page 4<br><br>medical documentation for residents;<br>- a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and<br>-a method of sharing information from the EP with residents and their families;<br>- EP training and testing program;(must conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP); and<br>- EP training program for staff (including documentation of training provided).<br><br>On December 7, 2022 at 1:30 p.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A verified the emergency preparedness plan lacked all required content.<br><br>No additional information was provided.<br><br>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<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee | 0 800 | | |

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| 0 800 | Continued From page 5<br>failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).<br><br>The findings include:<br><br>On December 7, 2022, from approximately 11:45 a.m. to 2:00 p.m., survey staff toured the facility with the director of maintenance (DOM)- E. During the facility tour, survey staff observed the following:<br><br>2nd Floor:<br>Three Pines:<br>1. There was damage on the walls by the main entrance to the space caused by residents using wheelchairs. Similar damage was found in resident rooms B103 and B106. DOM-E stated they were aware of the damage and it was on the maintenance schedule.<br>2. The storage room was missing the escutcheon for the sprinkler head.<br><br>Pinewood:<br>1. There were large holes in the ceiling of the dining room which the DOM-E stated were from speakers being removed. The ceiling had not been patched at the time of the survey. | 0 800 | | |

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| 0 800 | Continued From page 6<br><br>1st Floor:<br>Birchwood:<br>1. There was damage on the walls and nurse's station caused by residents using wheelchairs.<br>2. Wallpaper by the exit door had been peeled by a resident.<br><br>Willow:<br>1. The sprinkler head in the spa was covered in lint and dust.<br>2. Miscellaneous items were being stored in the egress path to an exit.<br>3. There was a significant amount of dead boxelder bugs in one of the egress corridors that could potentially be a slipping hazard in an emergency.<br><br>Some exits were not cleared of snow and ice around the outside of the building. Stoops, stairs, and walkways should all be maintained free of snow and ice when the door is marked as part of the path of egress.<br><br>DOM-E verbally confirmed survey staff observations during the facility tour.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms; | 0 810 | | |

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| 0 810 | Continued From page 7<br><br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 0 810 | | |

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| 0 810 | Continued From page 8<br>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 residents).<br><br>The findings include:<br><br>During interview on December 7, 2022, at 2:30 p.m., the director of maintenance (DOM)-E stated they had only done a few evacuation drills.<br><br>Review of the fire safety policy showed the following:<br><br>1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who need assistance during an evacuation. The policy stated to evacuate residents to opposite household but did not include information regarding evacuation priority or how residents who need assistance are identified to staff.<br><br>2. Evacuation drills completed on 08/04/2022, 10/20/2022, and 11/17/2022.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 970 SS=F | 144.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility | 0 970 | | |

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| 0 970 | Continued From page 9<br>liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 94 residents residing in the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On December 5, 2022, at 10: 30 a.m., a copy of the facility's assisted living contract was requested.<br><br>The undated Wealshire Resident Agreement/Assisted Living with Dementia Care form (assisted living contract), included clauses indicating the facility was not liable to residents in the following incidents:<br><br>Personal Property: | 0 970 | | |

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| 0 970 | Continued From page 10<br><br>The Wealshire was not responsible for the loss of or damage to a resident's personal property due to theft, fire, water, vandalism or any other cause unless such loss is caused by the negligent or intentional acts of the Community or its employees.<br><br>Liability for Damage:<br>The resident was required to reimburse The Wealshire for the repair to the Suite and for the repair or replacement of furnishings and fixtures owned by the Community in the Suite above and beyond ordinary wear and tear. In addition, the resident was required to reimburse The Wealshire for any loss or damage to the Community's real or personal property outside the Suite caused either intentionally or negligently by the resident or their visitors.<br><br>On December 7, 2022, at 1:30 p.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A stated the licensee was not aware the contract could not require residents to waive the facility's liability and responsibility for health, safety, or personal property. LALD/RN-A stated the same assisted living contract was used for all residents residing in the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |
| 01470 SS=F | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics: | 01470 | | |

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| 01470 | Continued From page 11<br>(1) an overview of this chapter;<br>(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;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(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<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(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: | 01470 | | |

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| THE WEALSHIRE OF BLOOMINGTON | 10601 LYNDALE AVENUE SOUTH BLOOMINGTON, MN 55420 |

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| 01470 | Continued From page 12<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of two employees (unlicensed personnel (ULP)-F, licensed practical nurse (LPN)-H).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).<br><br>The findings include:<br><br>ULP-F's employee record lacked documentation of required training.<br><br>ULP-F had a hire date of October 8, 2019.<br><br>LPN-H's employee record lacked documentation | 01470 | | |

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| 01470 | Continued From page 13<br>of required training<br><br>LPN-H had a hire date of December 29, 2020.<br><br>ULP-F's and LPN-H's records lacked documentation the following orientation topics were completed:<br>-An overview of assisted living laws 144.G.<br>-an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person.<br><br>On December 7, 2022, at 1:30 p.m. licensed assisted living director who was also the registered nurse (LALD/RN)-A confirmed the licensee's employees had not completed the above listed required orientation topics. LALD/RN-A and Operations Manager (OM)-B stated employees were hired prior to the August 1, 2021. Although OM-B stated the licensee completed a PowerPoint presentation for all staff, OM-B verified the licensee lacked documented evidence this was provided for ULP-F and LPN-H.<br><br>The licensee's Assisted Living with Memory Care Dementia Training policy dated August 1, 2021, indicated all assisted living staff would receive required training on dementia care during orientation and annually. The policy lacked identification of an overview of assisted living laws 144.G.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01470 | | |

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| 01730 | Continued From page 14 | 01730 | | |
| 01730 SS=D | 144G.71 Subd. 5 Individualized medication management plan<br><br>(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 each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(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;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(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.<br>(b) The medication management record must be current and updated when there are any | 01730 | | |

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| 01730 | Continued From page 15<br>changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to develop an individualized medication management record with the required content for two of five residents (R1, R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1's record lacked development and implementation of an individualized medication management record.<br><br>R1's service plan dated October 1, 2022, indicated R1 received Med: Administration services effective October 1, 2022.<br><br>R1's record included Medication Assessment Admission form dated October 1, 2022, but lacked all required content for development and implementation of an individualized medication management record. | 01730 | | |

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| 01730 | Continued From page 16<br><br>R2's record lacked development and implementation of an individualized medication management record.<br><br>R2's service plan dated October 1, 2022, indicated R1 received Med: Administration services effective October 1, 2022.<br><br>R2's recorded included Medication Assessment form dated October 1, 2022 but lacked all required content for development and implementation of an individualized medication management record.<br><br>R1 and R2 lacked development of an individualized medication management record, based on the residents' assessments which contained the following:<br>- a statement describing the medication management services that would be provided;<br>- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>- documentation of specific resident instructions relating to the administration of medications;<br>- identification of persons responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis;<br>- identification of medication management tasks that may be delegated to unlicensed personnel (ULP);<br>- procedures for staff notifying a registered nurse (RN) or appropriate licensed health professional when a problem arose with medication management services; and<br>- any resident-specific requirements relating to documenting medication administration, verifications that all medications were administered as prescribed, and monitoring of | 01730 | | |

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| 01730 | Continued From page 17<br>medication use to prevent possible complications or adverse reactions.<br>- The medication management record must be current and updated when there were any changes.<br>- Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber was providing medication management.<br><br>The Wealshire Policies and Procedures - Medication Management Services policy dated August 1, 2021, included all required content for developing and maintaining a current individualized medication management record for residents receiving medications management services according to Minnesota Statute 144G.71 subd. 5.<br><br>On December 7, 2022, at 1:30 p.m., licensed assisted living director, who was also the RN (LALD/RN)-A, verfied R1's and R2's records lacked development of an individualized medications management record. LALD/RN-A stated they were not aware the medication management record needed to be detailed and needed to be more specific on who provided the service. LALD-D further explained the licensee considered the medication administration record (MAR) to be part of the medication management record.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs | 01890 | | |

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| 01890 | Continued From page 18<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medication with a shortened expiration date labeled with a date when opened or expired for one of one resident (R7).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>On December 6. 2022, at 11:15 a.m. the following was observed in the Birchwood medication cart with licensed practical nurse (LPN)-D<br>R7 -Brimonidine, a solution used to lower pressure in the eyes<br>-Dorzolamide, used to treat glaucoma, a condition in which increased pressure in the eye can lead to gradual loss of vision. LPN-D stated the licensee did not instruct her to label eye drops when opened.<br><br>On December 6. 2022, at 11:45 a.m., the | 01890 | | |

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| 01890 | Continued From page 19<br><br>medication cart was observed on the Elmwood unit with licensed assisted living director, who was also the RN (LALD/RN)-A,. LALD/RN-A stated the facility did not instruct staff to mark eye drops with an open date and added this practice was "true of the facility."<br><br>Manufacture's Guidelines for brimonidine tartrate directs users to discard the eye drops 4 (four) weeks after opening and to write the date on the bottle when opened and throw out any remaining solution after four weeks.<br><br>Manufacture's Guidelines for Dorzolamide directs staff to throw out 28-days after opening, even if there was solution left.<br><br>On December 7, 2022, at 1:30 p.m., LALD/RN-A stated stickers to apply to medication labels were ordered from pharmacy to date medications with shortened expiration dates and staff would be educated on this practice.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy | 01940 | | |

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| 01940 | Continued From page 20<br>management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of five residents (R3, R5).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). | 01940 | | |

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| 01940 | Continued From page 21<br><br>The findings include:<br><br>R3<br>R3 had diagnoses to include diabetes. On December 6, 2022, at 7:30 a.m. licensed practical nurse (LPN)-H observed to check R3's blood glucose level. R3's service plan dated September 6, 2022, indicated R3 received services which included assistance with medication management, laundry, and housekeeping. R3's service plan included a written statement for the treatment services being provided, which included blood glucose monitoring. and oxygen.<br><br>R5<br>R5 had diagnoses to include type II diabetes mellitus. On December 6, 2022, at 7:55 a.m. LPN-H observed R5's blood glucose check. R5's service plan dated September 20, 2022, indicated R3 received services which included assistance with bathing, dressing, grooming, and medication management. R5's service plan included a written statement for the treatment services being provided, which included blood glucose monitoring.<br><br>R3's and R5's records lacked Treatment and Therapy Management Plans to include:<br>- documentation of specific resident instructions relating to the treatment or therapy administration; and<br>- identification of treatment or therapy tasks that would be delegated to unlicensed personnel.<br>- any resident-specific requirements relating to documentation of treatment and therapy received verification all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. | 01940 | | |

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| 01940 | Continued From page 22<br><br>On December 7, 2022, at 1:30 p.m. Licensed Assisted Living Director, who was also the registered nurse (LALD/RN)-A verified R3's and R5's record lacked documentation of a current individualized treatment and therapy management which included the content listed above.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01940 | | |
| 02110 SS=F | 144G.82 Subd. 3 Policies<br><br>(a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:<br>(1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;<br>(2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;<br>(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;<br>(4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;<br>(5) staff training specific to dementia care;<br>(6) description of life enrichment programs and | 02110 | | |

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| 02110 | Continued From page 23<br>how activities are implemented;<br>(7) description of family support programs and efforts to keep the family engaged;<br>(8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;<br>(9) transportation coordination and assistance to and from outside medical appointments; and<br>(10) safekeeping of residents' possessions.<br>(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to five of five residents (R1, R2, R3, R4, R5).<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On December 5, 2022, at 10:00 a.m., during the entrance conference, licensed Assisted Living Director, who was also the registered nurse (LALD/RN)-A stated the licensee operated under an assisted living facility with dementia care license as of August 1, 2021. | 02110 | | |

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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 |
|---|---|---|---|---|
| 02110 | Continued From page 24<br><br>R1, R2, R3, R4, and R5 had admission dates of October 1, 2022, January 11, 2019, May 9, 2019, June 22, 2022, and March 2, 2020, respectively. The identified resident records all lacked documentation for receipt of required policies and procedures to be provided at the time of move-in to the facility.<br><br>On December 7, 2022 at 1:30 p.m. LALD/RN-A verified R1, R2, R3, R4, and R5's records lacked documentation as identified above.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02110 | | |

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/05/22*
Time: 13:25:16
Report: 1004221318

# Food and Beverage Establishment Inspection Report



**Location:**
The Wealshire Of Bloomington
10601 Lyndale Avenue South
Bloomington, MN55420
Hennepin County, 27

**Establishment Info:**
ID #: 0037517
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 9523451900
ID #:

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

The following orders were issued during this inspection.

**3-300C Protection from Contamination: equipment/utensils, consumers**

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

-WIPING CLOTHS FOUND STORED IN A SOAPY WATER SOLUTION. DISCONTINUE AND ENSURE WIPING CLOTHS ARE STORED IN A SANITIZER SOLUTION.

-WET WIPING CLOTH BUCKET FOUND WITH A QUATERNARY AMMONIUM CONCENTRATION OF <50PPM.

*CORRECTED ON SITE.

*Corrected on Site*

**Surface and Equipment Sanitizers**

Rinse Temp. Gauge: = at 198 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Utensil Surface Temp.: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: 3-COMPARTMENT SINK
Violation Issued: No

Quaternary Ammonia: = 50PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: Yes

Quaternary Ammonia: = 150PPM at  Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: CHICKEN
Temperature: 40 Degrees Fahrenheit  - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit  - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: BUTTER
Temperature: 38 Degrees Fahrenheit  - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: <40 Degrees Fahrenheit  - Location: ELM DINING ROOM REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: <40 Degrees Fahrenheit  - Location: WILLOW DINING ROOM REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: <40 Degrees Fahrenheit  - Location: PINEWOOD DINING ROOM REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: <39 Degrees Fahrenheit  - Location: THREE PINES DINING ROOM REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: <39 Degrees Fahrenheit  - Location: FOUR OAKS DINING ROOM REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: <39 Degrees Fahrenheit  - Location: BIRCH DINING ROOM REFRIGERATOR
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY MARY BRUESS.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-DATE MARKING PROCEDURES
-COOLING PROCEDURES

-REHEATING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-LOGS (COOLER TEMPERATURE, SANITIZER CONCENTRATIONS, HIGH TEMP DISH MACHINE UTENSIL SURFACE TEMPERATURES, ETC)
-PHYSICAL FACILITIES AND MAINTENANCE
-ALL VIOLATIONS ON THIS REPORT

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT, OR CALL ON THEIR BEHALF. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

**REPORTS WAS DISCUSSED WITH THE DIETARY DIRECTOR, SHEILA, AND THE NURSE EVALUATOR, MARY.

**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 1004221318 of 12/05/22.

Certified Food Protection Manager: SHEILA MILLER

Certification Number: FM82588 Expires: 02/19/25

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

Signed: _____
SHEILA MILLER
DIETARY DIRECTOR

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us