DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 9, 2023

Licensee
Hillcrest Nashwauk
570 Platt Avenue East
Nashwauk, MN 55769

RE: Project Number(s) SL26487015

Dear Licensee:

On May 23, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 6, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

Electronically Delivered

April 24, 2023

Licensee
Hillcrest Nashwauk
570 Platt Avenue East
Nashwauk, MN 55769

RE: Project Number(s) SL26487015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 6, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statutes, Chapter 144A and/or Minn. Stat. § 626.5572 and/or Minn. Stat. Chapter 260E.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state 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 . . ."

In accordance with Minn. Stat. § 144A.474,Subd. 11, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey at your agency**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144A.474, Subd. 8(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's client(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. § 144A.474, Subd. 12, 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 MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144A.44 Subd. 1(14), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26487	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NASHWAUK	570 PLATT AVENUE EAST NASHWAUK, MN 55769

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL26487015 On April 3, 2023, through April 6, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 40 active residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the	0 485		

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0 485	Continued From page 1 following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure weekly menus were made available to the residents. This had the potential to affect all 40 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 3, 2023, during a tour of the licensed facility at 9:40 a.m., the surveyor observed the menu for the day written on a white board in the	0 485		

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0 485	Continued From page 2 dining area, however, the weekly menu was not observed. On April 3, 2023, directly following the above observation, licensed assisted living director/owner (LALD/O)-A stated someone could have taken the weekly menu down. LALD/O-A added weekly menus were not provided to residents. During the entrance conference on April 3, 2023, at approximately 10:05 a.m., LALD/O-A stated the licensee provided three meals daily to include fresh fruits and vegetables and snacks were offered. On April 6, 2023, at approximately 12:15 p.m., LALD/O-A and licensed practical nurse (LPN)-D confirmed weekly menus were not provided to the residents or posted. LPN-D commented many times the facility had issues getting food that was ordered. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be	0 630		

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0 630	Continued From page 3 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 (IAPP) was developed to include all the required content for one of three (R5) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R5's diagnoses included suicidal behavior, cerebral infarction (damaged tissues of the brain from a lack of blood supply), and major depressive disorder. R5's Service Plan dated March 31, 2023, included medication management, bathing, safety checks, blood pressure and pulse monitoring, housekeeping and laundry. On April 4, 2023, at 9:16 a.m., the surveyor observed unlicensed personnel (ULP)-E obtain R5's blood pressure reading and administer R5's morning medication.	0 630		

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0 630	Continued From page 4 R5's IAPP dated March 3, 2023, identified areas of vulnerabilities with interventions; however, lacked a review of R5's risk to abuse other vulnerable adults. On April 6, 2023, at 12:55 p.m., registered nurse/owner (RN/O)-B confirmed R5's IAPP did not assess R5's risk to abuse others. The licensee's Individual Abuse Prevention Plan dated July 12, 2022, the licensee would develop and implement an IAPP for each vulnerable adult. The plan would 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 adult; 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an	0 680		

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0 680	Continued From page 5 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 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 post an exit diagram on each level of the facility. In addition. the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 6 EXIT DIAGRAMS On April 3, 2023, at 9:45 a.m., during a tour of the facility with living director/owner (LALD/O)-A the surveyor did not observe posted exit diagrams on the main or upper level of the facility. On April 3, 2023, directly following the above observation LALD/O-A stated someone may have taken down the exit diagrams. LALD/O-A confirmed exit diagrams were not posted on either level of the facility. EPP The licensee's EP, last reviewd March 2023, failed to include the following: -current, all-hazards approach facility assessment; -identifying population at risk; and -procedures for tracking of staff and patients. On April 3, 2023, at 12:11 p.m., LALD/O-A stated she "thought" only dementia sites needed to have a risk assessment, identify population at risk, and have a system to track residents and staff. On April 3, 2023, at 12:30 p.m., LALD/O-A confirmed the facility's EPP was not fully developed as required. The licensee's Disaster Planning and Emergency Preparedness policy dated July 9, 2021, indicated the facility would post emergency exit diagrams on each floor of the facility. In addition, this policy indicated the facility would have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS (Centers for Medicare & Medicaid Services) Appendix Z.	0 680		

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0 680	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide compliant smoke alarms in the resident rooms throughout the facility. This	0 780		

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0 780	Continued From page 8 deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 5, 2023, at approximately 11:00 a.m. with maintenance (M)-F it was observed that several smoke alarms were installed in resident rooms throughout the facility but did not activate upon pushing the test button. It was found that the smoke/ carbon monoxide combination alarms were beyond the required replacement date identified by the manufacture and therefore would not test properly. Smoke/ carbon monoxide combination alarms are required to be maintained according to the manufactures listing and installation instructions. It was also observed a smoke alarm was missing in the bedroom of resident room 207. Smoke alarms are required to be installed and maintained according to the design and installation at the time of construction. This deficient finding was visually verified by M-F at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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0 800	Continued From page 9	0 800		
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 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. 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 potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 5, 2023, at approximately 11:00 a.m. with maintenance (M)-F it was observed that door closers were removed from several fire-resistant rated doors throughout the facility. Door closers on fire resistant rated doors are required to be maintained as design and installed at the time of construction.	0 800		

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0 800	Continued From page 10 It was also observed a backflow prevention device was not provided on the faucet of the floor sink in the utility room where the sprinkler riser and domestic type clothes washer and dryer are located. The available documentation indicated the facility had not completed cleaning of the commercial kitchen hood and duct system as required. These deficient conditions were visually verified by M-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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 11 (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 record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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). A record review of available documentation and interview were conducted on April 5, 2023, at approximately 10:15 a.m. of documents provided by licensed assisted living director (LALD)-A maintenance (M)-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include:	0 810		

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0 810	Continued From page 12 Record review of the available documentation indicated that the licensee did not have specific employee actions for this facility to be taken in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees regarding resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. All deficiencies were verified by LALD-A and M-F during the interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26487	A. BUILDING: _____ B. WING _____	04/06/2023

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0 970	Continued From page 13	0 970		
0 970 SS=B	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for two of four (R5, R6) residents. 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 of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: The licensee's Assisted Living Contract included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. R5's Assisted Living Contract signed March 29, 2022, included the following language indicating a	0 970		

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0 970	Continued From page 14 waiver of liability: Page 15, section 2. Indemnification indicated the resident would indemnify and hold harmless provider, its employees and agents against any and all claims, actions, damages and liability and expenses in connection with loss of life, personal injury or damage to property, or caused wholly or in part by an act of omission of resident. R5 and R6's Assisted Living Contract signed March 29, 2022, and September 12, 2022, respectively included the following language: Page 15 and 16, section 4. Liability indicated the provider was not liable to resident for any injury, death or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by resident... Provider may be liable to resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold provider harmless from any and all claims for injuries. property damage or any other loss resulting from an accident or other occurrence in the apartment unit or on provider's premises. On April 6, 2022, at 12:20 p.m., licensed assisted living director/owner (LALD/O)-A stated she was responsible to maintain the Assisted Living Contract and the contract was updated October 3, 2022, where the Indemnification and Liability language was removed. LALD/O-A confirmed R5 and R6's contracts had not been updated to the new Assisted Living Contract. No further information was provided.	0 970		

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0 970	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case	01060		

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01060	Continued From page 16 manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 The licensee's Discharge Resident/Client Roster dated October 3, 2022, to April 3, 2023, indicated R1 was admitted on April 9, 2018, and discharged on February 7, 2023. Discharge reason, transfer to another AL (assisted living.)	01060		

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01060	Continued From page 17 R1's service plan dated July 1, 2022, indicated R1 received the following services: behavior management, medication administration, blood glucose monitoring, oxygen saturation monitoring daily, temperature daily, safety checks, skin care daily, and housekeeping services. R1's RTasks (on-line documenting service) notes written by clinical nurse supervisor (CNS)-C included: - February 1, 2023, at 2:39 p.m., aid brought to CNS-C's attention R1's blood pressure was low, 83/39, pulse 54. CNS-C assessed client; client seemed slightly weaker than baseline, color pale, no noted cyanosis to lips. Client denied SOB (shortness of breath), lungs clear. Client stated he believed he had some blood in his stool and complained of blood in urine. Client had recent issues with nose bleeds that had since resolved. Client complained of slight headache, no other pain. Blood pressure was rechecked and found to be 80/30. Emergency services called, and paperwork sent. Client's dentures and call light left in room; - February 2, 2023, at 3:19 p.m., spoke with ICU (intensive care unit) nurse at (name of hospital) for update. Resident was admitted; and - February 6, 2023, at 11:04 a.m., resident was transferred from (name of hospital) to (named assisted living) for Hospice care. R1's discharge-transfer summary dated February 7, 2023, noted discharge reason, transfer to another AL. R1's record lacked a written notice that contained, at a minimum: - the name and contact information for the location to which the resident has been relocated and any new service provider;	01060		

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01060	Continued From page 18 - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. R2 R2's service plan dated November 22, 2022, indicated R2 received the following services: colostomy assist PRN (as needed or desired), medication administration, blood glucose monitoring, vital sign monitoring, laundry and housekeeping services. On April 4, 2023, at 8:25 a.m., the surveyor observed clinical nurse supervisor (CNS)-C change R2's colostomy bag and unlicensed personnel (ULP)-E administer R2's oral morning medications, check R2's blood glucose level, and administer R2's insulin. R2's record included a discharge summary from (name of hospital) noting R2's admission date was February 22, 2023, and R2's discharge date was February 27, 2023. R2's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the	01060		

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01060	Continued From page 19 location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On April 3, 2023, at 11:47 a.m., registered nurse/owner (RN/O)-B stated notification was not sent to OOLTC for R1 adding the facility was not aware of the requirement at that time, "it" (information) came out from Care Providers (association for post-acute care and long-term services and support). On April 4, 2023, at 9:40 a.m., RN/O-B stated notification was not sent to OOLTC for R2's hospitalization stay that was greater than four (4) days. RN/O-B added before March the OOLTC had not been notified. RN/O-B stated the form from Care Providers came out in February but "it took a while to get it rolled out." The licensee's Emergency Relocation policy dated March 10, 2023, indicated in the event of an emergency relocation, the facility would provide a written notice that contains, at a minimum: -the reason for the relocation;	01060		

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01060	Continued From page 20 -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal; - the facility would provide contact information for the agency to which the resident may submit an appeal; -the notice required would be delivered as soon as practicable to the resident legal representative and designated representative; -for the resident who received home and community-based wavier services, the resident's case manager; and -the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the tacitly within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the	01620		

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01620	Continued From page 21 resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment every 90 days for two of four residents (R6, R5). 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:	01620		

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01620	Continued From page 22 R6 R6's diagnoses included Alzheimer's disease, high blood pressure, anxiety, and schizoid personality disorder. R6's Service Plan dated March 27, 2023, indicated R6 received medication management, bathing, dressing, grooming, toileting reminders, skin care, blood pressure, pulse and weight monitoring, housekeeping and laundry. On April 4, 2023, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R6's morning medication. R6's 90-Day Assessments were completed on December 15, 2022, and March 27, 2023, for a total of 102 days in between assessments the RN. R5 R5's diagnoses included suicidal behavior, cerebral infarction (damaged tissues of the brain from a lack of blood supply), and major depressive disorder. R5's Service Plan dated March 31, 2023, indicated R5 received medication management, bathing, safety checks, blood pressure and pulse monitoring, housekeeping and laundry. On April 4, 2023, at 9:16 a.m., the evaluator observed ULP-E check R5's blood pressure, administer R5's morning oral medications and place topical ointment on R5's knees. R5's 90-Day Assessments were completed on November 28, 2022, and March 3, 2023, for a total of 95 days in between assessments by the RN.	01620		

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01620	Continued From page 23 On April 6, 2023, at 12:32 p.m., RN/owner (RN/O)-B stated there was a tracking system in RTasks (electronic health record) for resident assessments which alerted 14-days in advance when the resident assessments were due. RN/O-B stated it was the expectation resident assessments were completed timely and within the 90-day required timeframe. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2022, indicated ongoing reassessments and monitoring would be conducted by the RN as needed based on changes in the needs of the resident but could not exceed 90 days from the date of the last assessment. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the medications were stored according to manufacturer's instructions by maintaining acceptable medication refrigerator temperatures for six of six residents (R7, R4, R8, R3, R2, R9).	01880		

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01880	Continued From page 24 In addition, the licensee failed to ensure medication was secured in a locked area for R2. 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: MEDICATION STORED ACCORDING TO MANUFACTURER'S RECOMMENDATIONS On April 3, 2023, at 10:35 a.m., the surveyor reviewed the contents of the locked medication refrigerator with registered nurse/owner (RN/O)-B. RN/O-B stated the current temperature of the refrigerator was 38 degrees Fahrenheit (F). The surveyor reviewed temperature log for the month of March 2023 with RN/O-B. RN/O-B observed the medication refrigerator and confirmed the following contents: -one (1) unopened Rhopressa 0.02% (pressure reducing eye solution) for R7; -four (4) unopened Lantus 100 units/ milliliter (ml) (long-acting) insulin pens for R4; -15 unopened Aspart 100 units/ml (rapid-acting) insulin pens for R8; -eight (8) unopened Lantus 100 units/ml insulin pens for R3; -three (3) unopened Novolog 100 units/ml (short acting) insulin pens for R2; -five (5) unopened Basaglar 100 units/ml (long-acting) insulin pens for R2; and -five (5) unopened Levemir 100 units/ml	01880		

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01880	Continued From page 25 (long-acting) insulin pens for R9. The refrigerator/freezer temperature chart dated March 1, 2023, through March 31, 2023, indicated the following: -the temperature was recorded 29 out of 31 opportunities; -13 out of 29 opportunities the temperatures were out of range and documented below 36 degrees F. The manufacturer's instructions for Rhopressa dated December 2017, indicated to store until opened in the refrigerator between 36-46 degrees F. The manufacturer's instructions for Lantus insulin dated March 2020, indicated to store unopened Lantus in a refrigerator between 36-46 degrees F. Do not allow Lantus to freeze. The manufacturer's instructions for Aspart insulin dated May 15, 2020, indicated to store unopened Aspart in a refrigerator between 36-46 degrees F, but do not freeze them. Discard any insulin Aspart product that has been exposed to extreme heat or cold. The manufacturer's instructions for Novolog insulin dated January 2019, indicated to store unopened Novolog in a refrigerator between 36-46 degrees F. Do not allow Novolog to freeze. The manufacturer's instructions for Basaglar insulin dated July 2021, indicated to store unopened Basaglar insulin in the refrigerator between 36-46 degrees F. Do not allow Basaglar to freeze. The manufacturer's instructions for Levemir	01880		

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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
01880	Continued From page 26 insulin dated September 2022, indicated to store unopened Levemir insulin pens in the refrigerator between 36-46 degrees F. Do not allow Levemir to freeze. Do not use Levemir if it has been frozen. SECURE MEDICATION STORAGE On April 3, 2023, at 1:13 p.m., the surveyor observed licensed practical nurse (LPN)-D take R2's blood glucose, administer oral medication, and administer 10 units of Novolog insulin in R2's lower left abdomen. Directly following the above medication administration, the surveyor observed a small, opened bottle of acetaminophen 500 milligrams sitting on a bedside table in R2's room. R2's Individualized Medication Management Plan dated January 20, 2023, indicated staff would administer all medications per MD (medical doctor) orders. In addition, all medication would be locked behind key-access lock and locked safe; designated staff only have access to all medication; medication is not to be left unattended by administering staff. On April 3, 2023, at 3:16 p.m., RN/O-B stated she was not comfortable with R2 having medications at bedside. RN/O-B confirmed R2's acetaminophen 500 mg should have been locked up. The licensee's Medication Storage policy dated July 12, 2022, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). In addition, medications would be stored consistent with each resident's	01880		

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	26487	A. BUILDING: _____ B. WING _____	04/06/2023

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01880	Continued From page 27 medication management plan and service plan. Medications managed by the facility would be stored to prevent diversion of medications by residents or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained with legible information including the expiration date for time sensitive medications for two of ten residents (R10, R11). 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).	01890		

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01890	Continued From page 28 The findings include: On April 3, 2023, at 10:45 a.m., the evaluator toured the facility with registered nurse/owner (RN/O)-B, including a review of the locked medication carts, West medication cart and East medication cart. RN/O-B observed and confirmed the following from the West medication cart: R10 R10's Symbicort 160/4.5 microgram (mcg) inhaler (corticosteroid) lacked a label to indicate when the inhaler had been removed from its foil pouch and when the inhaler would expire. R11 R11's opened Advair Diskus (difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by asthma) 250 mcg/50 milligrams (mg) inhaler, lacked a date the inhaler was removed from the foil package and when the inhaler would expire. The manufacturer's instructions for Symbicort inhaler dated 2019, directed to discard three (3) months after removal from foil pouch. The manufacturer's instructions for Advair Diskus dated 2019, directed to discard 30 days after removal from foil pouch. The licensee's Medication Storage policy dated July 12, 2022, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

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01890	Continued From page 29 days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of two residents (R1) upon discharge. 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	01910		

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01910	Continued From page 30 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 was admitted on April 9, 2018, and discharged on February 7, 2023. R1's diagnoses included atrial fibrillation, hypothyroidism, hypertension (HTN), muscle weakness, history of falls, adult failure to thrive, chronic systolic heart failure. R1's service plan dated July 1, 2022, indicated R1 received medication administration seven (7) times daily. R1's Discharge-Transfer Summary, dated February 7, 2023, indicated R1 received: -atorvastatin (high cholesterol) 40 milligrams (mg) one daily: -clopidogrel (atrial fibrillation) 75 mg daily; -doxazosin 4 mg, (urinary retention) daily; -Eliquis 5 mg (atrial fibrillation) twice daily; -furosemide (fluid retention) 20 mg daily; -Lantus Solostar 100 unit/milliliter (ml) long-acting insulin 28 units twice daily; -levothyroxine (hypothyroid) 125 micrograms (mcg) daily; -lisinopril (heart) 20 mg daily, -metoprolol succinate (HTN) 100 mg ER (extended release) daily, -Myrbetriq (urinary frequency) 50 mg ER daily: -polyvinyl eye drop 1.4 %, 15 ml 1 drop both eyes four (4) times daily, and -Tab-A-Vite, daily. As needed medications (prn) included: -A & D ointment;	01910		

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01910	Continued From page 31 -acetaminophen 325 mg; -advanced antacid liquid; -bacitracin 500 unit ointment; -Deep Sea 0.65% nasal spray; -loperamide 2 mg capsule; -nitroglycerin 0.4 mg tablet; and -Tussin DM cough/chest congestion solution. R1's prescriber's orders certification period January 31, 2021, to January 31, 2022, included all of the above medications. R1's Med Disposition Summary indicated the following medications were disposed February 13, 2023: -cepalexin (antibiotic) 500 mg, 21 quantity (qty), provider order to discontinue, mixed with coffee grounds; -nitroglycerin (chest pain) 0.4 mg, 25 qty, medication expired, mixed with coffee grounds; -nitroglycerin 0.4 mg, 25 qty, resident discharged, mixed with coffee grounds; and -Deep Sea 0.65% nasal spray, 1 qty, resident refused medication, mixed with coffee grounds. R1's RTasks (on-line documentation system) note dated February 6, 2023, noted, resident was transferred from [hospital] to [assisted living] for hospice care. Medications picked up by nurse from [assisted living], family in process of moving apartment belongings. Resident discharged effective February 6, 2023. On April 3, 2023, at 11:31 a.m., registered nurse/ owner (RN/O)-B stated there were no amounts of all R1's medications found in R1's record. RN/O-B stated R1 was on cycle medications, and it "looks like the family picked them up from the pharmacy." RN/O-B confirmed R1's record failed to include a completed medication	01910		

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01910	Continued From page 32 disposition/disposal record. The licensee's Medication Disposal policy dated July 12, 2022, indicated upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatment or therapies were administered as directed and failed to document the reason they were not administered, and any follow up procedures provided to meet	01960		

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01960	Continued From page 33 the resident's needs for two of four residents (R2, R4) with treatments. 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: R2 R2's admission date was November 7, 2022. R2's diagnoses included A-fib, depression, hypertension (HTN), asthma, colostomy, and borderline diabetes. On April 4, 2023, at 8:25 a.m., the surveyor observed clinical nurse supervisor (CNS)-C change R2's colostomy bag and unlicensed personnel (ULP)-E administer R2's oral morning medications, check R2's blood glucose level, and administer R2's insulin. R2's service plan dated November 22, 2022, indicated R2 received the following services: colostomy assist PRN (as needed or desired). R2's prescriber's orders, dated March 29, 2023, included: change ostomy appliance every 2 days and as needed until skin is healed and follow up in wound care in 2 weeks or as needed for acute concerns.	01960		

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01960	Continued From page 34 R2's Resident Notes-Include Service Notes, dated March 27, 2023, through April 6, 2023, referring to ostomy included: -March 27, 2023, at 5:34 p.m., documented by CNS-C, "Went into ER (emergency room) today related to chest pain, weakness, hypotension.... Updated nurse of problems with stoma and resident was to have wound care with (provider) tomorrow. Their plan was to put a wound consult in to have (provider) see him today or tomorrow for contained issues with the ostomy. At this time there is no plan for discharge. Resident was discharged home today with no new medication. Resident was able to see wound care in hospital and change his ostomy bag to convex from a Hollister. Marathon barrier was used on skin at reddened areas. Resident had stress test and Echo completed, will upload into chart once received from hospital. Resident has a follow up with (provider) next week on 4/4/23 and wound care follow up in 2 weeks on 4/12/23". -March 30, 2023, at 12:00 p.m., documented by CNS-C, "colostomy assist, bag was changed yesterday, not needed today". -March 30, 2023, at 4:32 p.m., documented by CNS-C, "ostomy change today, resident was complaining of some redness and itching around new deep convex bag that was placed yesterday. Resident stated that redness was spreading from previously. Attempted to change ostomy bag with deep convex ileostomy. Was unable to get a good seal with barrier wafer with Barrier ointment. Resident had alternate bag that this nurse was able to get an effective seal. Only had one other bag of deep convex will change next week and hopefully get supplies from (name of hospital) mid-week. Will use alternate supplies until able to get ordered supplies. Ostomy changed with	01960		

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01960	Continued From page 35 2-piece Hollister colostomy bag, Hollister barrier ring and marathon applied to reddened area surround stoma. 1 inch around stoma Ilex skin protectant applied. C-strips applied to our edges of ileostomy bag". -April 4, 2023, at 8:52 a.m., documented by CNS-C "PRN ostomy change completed today due to current bag leaking. Placed new bag per orders. Skin was slightly red around soma but has improved from previous change last week. Resident continues to complain of slight pain and itching to the area and does use his PRN hydroxyzine for relief which is effective for resident. Noted was moderate amount of green liquid stool from ileostomy. Apply Marathon to denuded skin, Ilex skin protectant was applied directly around stoma, used a protective barrier ring, Sensura Mio 16951 ostomy barrier, Sensura Mio 114272 pouch, Drainable. Barrier wipe dabbed to surrounding area where wafer was placed to have an effective seal and C-strip to lateral edges of barrier. Heat via warmth of hand to melt barrier ring". -April 5, 2023, at 12:00 p.m., documented by CNS-C: "ostomy care completed. Correct waffer (sic) and Pouch unavailable used waffer (sic)and pouch from previous order until new order supplies comes in from (name of company)". On April 6, 2023, at approximately 12:00 p.m., registered nurse/owner (RN/O)-B stated the order was to change R2's ostomy bag every two to three days. RN/O-B confirmed there was not documentation to support R2's provider's order was followed as ordered. RN/O-B commented there are times that R2's family was there, and they do the bag changes, and that R2 would do it himself at times.	01960		

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01960	Continued From page 36 R4 R4's admission date was January 19, 2023. R4's diagnoses included non-pressure chronic ulcer of left lower leg, venous insufficiency, HTN, and diabetes. R4's Service Plan updated February 7, 2023, indicated R4 received daily wound care by the RN. R4's prescriber orders included wound care ordered March 7, 2023, to left lower extremity to include cleansing the wound with mild soap and water, rinse pat dry, apply compounded ointment to dermatitis area on Thursday and Friday, dress wound with oil emulsion gauze, cover with dry 4 x 4 gauze and 5 x 9 abdominal pad and secure rolled gauze and Medipore tape (soft, breathable tape), and apply tubigrip (elastic tubular bandage) size E over the dressing. Change dressing daily. R4's Admission Assessment dated January 20, 2023, and 14-Day Assessment dated February 2, 2023, indicated R4's had a stage three (3) right lateral ankle ulcer and a stage three (3) left lateral calf ulcer. R4's wound assessment lacked a detailed description of the ulcers and measurements. R4's Individual Treatment and Therapy Plan dated April 4, 2023, directed the RN or licensed practical nurse was to complete wound care to left leg wound on Monday, Wednesday, and Friday or sooner if an increase in drainage. R4's Resident Notes dated March 1, 2023, through April 4, 2023, lacked documentation R4's leg ulcers were assessed and monitored to	01960		

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01960	Continued From page 37 determine the condition of R4's wounds. On April 6, 2023, at 12:22 p.m., RN/O-B stated R4 was being seen at the wound clinic and the wound clinic completed R4's wound measurements. RN/O-B stated the wound clinic didn't always communicate with the licensee's staff after R4's wound care visits. RN/O-B confirmed R4's records lacked current documentation of the description and/or measurements of R4's leg ulcer to determine if R4's leg ulcer was improving or worsening. RN/O-B further stated the RN would assess R4's wound at the next 90-day resident assessment. The licensee's Medication & Treatment Orders policy dated July 7, 2022, indicated the RN was responsible for assuring that: -current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the resident's records; -communicated to the resident or responsible party; -educate resident or responsible party on all medication and treatment orders, and -changes in orders are addressed in the resident's service plan and are communicated to the other staff; -an order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order; -an order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment; -upon receiving verbal orders or unsigned electronic orders, a licensed nurse would record and sign the order and forward the written order	01960		

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01960	Continued From page 38 to the prescriber for a signature after receipt of the verbal or electronic corer. The licensed nurse would continue to follow-up with the prescriber's office until the signature was received; -the licensed nurse would communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months or more frequently as needed; -the licensed nurse would review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition; -the license nurse would also monitor and evaluate mediation and treatment/therapy orders and services for effectiveness on a regular basis; and -a resident's MAR (medication administration record) and TAR (treatment administration record) would be audited regularly by a licensed nurse or designee for documentation compliance. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01960		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	03090		

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03090	Continued From page 39	03090		

failed to ensure signage was posted at the main entry of the building of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all 40 residents, staff and visitors of the licensee.

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).

Findings include:

On April 3, 2023, at 8:55 a.m., upon entry to the facility, at the main entrance, the evaluator observed a sign noting, "the common areas of the facility are under video surveillance" The evaluator observed no other signs for electronic monitoring at the facility.

On April 3, 2023, at 9:46 a.m., licensed assisted living director/owner (LALD/O)-A confirmed the facility failed to display statutory language for electronic monitoring. LALD/O-A added the last "surveyor" was going to email it to me, but never did. LALD/O added she looked for the correct wordage and found it, "I have different signs somewhere."

On April 6, 2023, at 11:31 a.m., LALD/O-A stated the facility had 22 cameras positioned in the hallways and commons area. In addition, there was a monitor behind an open desk area in the open entry/commons area that displayed eight (8) camera feeds. LALD/O-A added the monitor can be changed to display other cameras.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26487	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NASHWAUK	570 PLATT AVENUE EAST NASHWAUK, MN 55769

(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 40 The licensee's Electronic Monitoring policy dated July 12, 2022, indicated signs were installed at each community entrance accessible to visitors stating the following: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/03/23*
Time: 11:56:06
Report: 7939231050

Food and Beverage Establishment Inspection Report

Location:
Hillcrest Nashwauk
570 Platt Avenue East
Nashwauk, MN55769
Itasca County, 31

Establishment Info:
ID #: 0039277
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188851213
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

Hot Water: = at >160F Degrees Fahrenheit
Location: WARE WASH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: HAM
Temperature: 191 Degrees Fahrenheit - Location: COOKING
Violation Issued: No

Process/Item: POTATO
Temperature: 197 Degrees Fahrenheit - Location: COOKING
Violation Issued: No

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

Process/Item: SAUSAGE
Temperature: 38 Degrees Fahrenheit - Location: 2 DOOR FRIDGE
Violation Issued: No

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

DISCUSSION
EMPLOYEE ILLNESS LOG

VERY GOOD GLOVE USE

Food and Beverage Establishment Inspection Report

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 7939231050 of 04/03/23.

Certified Food Protection Manager: DAWN LALLI

Certification Number: FM70512 Expires: 06/05/25

Signed: NA

DAWN LALLI
MANAGER

Signed:

RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us