DEPARTMENT OF HEALTH

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

August 30, 2022

Administrator
Marywood
915 Kenwood Avenue
Duluth, MN 55811

RE: Project Number(s) SL31068015

Dear Administrator:

On August 12, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the May 6, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

Electronically Delivered

May 24, 2022

Administrator
Marywood
915 Kenwood Avenue
Duluth, MN 55811

RE: Project Number(s) SL31086015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 6, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

**IMPOSITION OF FINES**
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00**
**St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000.00**

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

**DOCUMENTATION OF ACTION TO COMPLY**
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up 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 Free from Maltreatment reconsideration

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

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

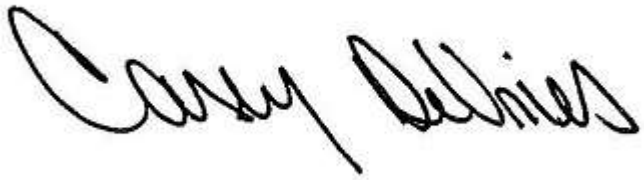
**REQUESTING A HEARING**

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

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

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

Sincerely,



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

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 31068 | A. BUILDING: _____ B. WING _____ | 05/06/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARYWOOD | 915 KENWOOD AVENUE DULUTH, MN 55811 |

| (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>Initial comments<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>SL31068015-0<br><br>On May 2, 2022, through May 6, 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 47 residents, all of whom received services under the provider's Assisted Living/with Dementia Care license.<br>An immediate correction order was identified on May 5, 2022, issued for SL31068015, tag identification 2310.<br>On May 6, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three and scope of widespread. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 110 SS=F | 144G.10 Subdivision 1a Assisted living director license required | 0 110 | | |

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| 0 110 | Continued From page 1<br>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's residents, staff and visitors.<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>LALD-A had a license effective through October 31, 2022. However, LALD-A's license lacked an organization listed as the Director of Record with BELTSS.<br><br>During the entrance conference on May 2, 2022, at approximately 1:06 p.m., LALD-A confirmed her license lacked the Director of Record as required.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) | 0 110 | | |

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| 0 110 | Continued From page 2<br>days | 0 110 | | |
| 0 500 SS=F | 144G.41 Subd. 2 Policies and procedures<br><br>Each assisted living facility must have policies and procedures in place to address the following and keep them current:<br>(1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;<br>(2) conducting and handling background studies on employees;<br>(3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;<br>(4) handling complaints regarding staff or services provided by staff;<br>(5) conducting initial evaluations of residents' needs and the providers' ability to provide those services;<br>(6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;<br>(7) orientation to and implementation of the assisted living bill of rights;<br>(8) infection control practices;<br>(9) reminders for medications, treatments, or exercises, if provided;<br>(10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards;<br>(11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; | 0 500 | | |

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| 0 500 | Continued From page 3<br>(12) medication and treatment management;<br>(13) delegation of tasks by registered nurses or licensed health professionals;<br>(14) supervision of registered nurses and licensed health professionals; and<br>(15) supervision of unlicensed personnel performing delegated tasks.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required, with records reviewed.<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>During entrance conference on May 2, 2022, at approximately 1:06 p.m., licensed assisted living director (LALD)-A and housing director (HD)-D stated they reviewed the current assisted living regulations in the Home Care & Assisted Living Laws & Rules text and online.<br><br>The licensee failed to ensure the following policies and procedures were in place and kept current: | 0 500 | | |

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| 0 500 | Continued From page 4<br>-supervision of registered nurses and licensed health professionals.<br><br>On May 6, 2022, at approximately 11:35 a.m., HD-D stated she was unable to locate a policy regarding the supervision of registered nurses and licensed health professionals.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 500 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for two of two employees (registered nurse (RN)-B, unlicensed personnel (ULP)-F) observed to administer insulin and perform blood glucose testing. In addition, | 0 510 | | |

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| 0 510 | Continued From page 5 | 0 510 | | |

the licensee failed to ensure infection control and safety for one of one employee (RN-B) observed to transport a contaminated insulin needle to dispose of.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On May 3, 2022, at approximately 11:09 a.m., the surveyor observed RN-B prepare to administer R8's insulin. RN-B wheeled R8 into his room, unlocked the cupboard where the medications and insulin were stored and removed the insulin. RN-B stated that she needed to go to get her tablet to ensure the amount of insulin and left the room. At 11:20 a.m., RN-B returned to the room, dialed the Novolog (short acting insulin) pen to one (1) unit, pushed the end of the pen, and then dialed to four (4) units. RN-B donned gloves, attempted to verify dose on the tablet but couldn't bring up the information, opened the cupboard to verify the dose on a printed piece of paper with the sliding scale, and administered the insulin to R8's abdomen. RN-B removed the needle from the insulin pen and placed the needle into the sharps container in the cupboard. Without removing her gloves, R8 put her hand into her pocket to retrieve her keys, unlocked the top cabinet door, touched the handle on the cabinet door, placed the insulin pen inside, locked the cabinet with her keys and put them back into her pocket, and then removed her gloves and

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| 0 510 | Continued From page 6<br>washed her hands in R8's bathroom sink.<br><br>On May 3, 2022, at approximately 11:29 a.m., RN-B stated she needed to administer R9's insulin prior to an outing for lunch. RN-B verified the dose according to R9's blood sugar obtained by the unlicensed personnel (ULP) and retrieved R9's Novolog insulin pen from his room. RN-B stated she needed to "prime" the pen with "one [1] unit" while the surveyor observed, and then dialed the insulin pen to administer two (2) units. RN-B retrieved gloves from a drawer near the kitchen, donned the gloves, and walked outside to an awaiting bus loaded with residents for the outing. RN-B asked accompanying staff to remove R9 from the bus so that she could give his insulin. Staff removed R9 from the bus and wheeled him into the entry way of the building. RN-B administered R9's insulin into his abdomen and alerted staff that she was finished. Holding the insulin pen with the contaminated needle upright in one gloved hand, RN-B walked back into the building, entered the locked Cliff Rock household walking through the common area, and into the nurse's office. RN-B removed the contaminated needle from the pen and placed it into the sharps container under the desk. RN-B removed her gloves and applied hand sanitizer.<br><br>On May 3, 2022, at approximately 2:38 p.m., RN-B confirmed she did not remove the gloves after administering R8's insulin and stated should not have completed other tasks until she performed hand hygiene. Also, RN-B stated she should have brought a small portable sharps container with her to dispose of the contaminated needle instead of carrying the contaminated needle from the outside of the building, through the household, and into the nurses' office. | 0 510 | | |

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| 0 510 | Continued From page 7<br><br>On May 4, 2022, at approximately 8:24 a.m., director of nursing (DON)-C stated gloves should be removed after administering insulin and hand hygiene should be performed.<br>On May 3, 2022, at approximately 11:00 a.m., the surveyor observed ULP-F perform a blood glucose check on R9 in his room. ULP-F performed hand hygiene, donned clean gloves, removed supplies from the cabinet in R9's room, wiped R9's finger with an alcohol wipe, poked it with the lancet, and applied blood to the glucometer. ULP-F then placed a tissue on the finger for R9, returned to the open cupboard, placed the lancet in the sharps container, put the glucometer and lancet machine in the cupboard, retrieved the key from around her neck to close the cupboard, removed her gloves, turned off the bathroom light, and performed hand hygiene on her way out of R9's room. Immediately after exiting the room, ULP-F verified she had not performed hand hygiene after removing her gloves, or before touching the key and cabinet and light, and stated she should have done it right after removing her gloves before touching anything.<br><br>On May 3, 2022, at approximately 2:27 p.m., registered nurse (RN)-B confirmed ULP-F should have performed hand hygiene after removing her gloves and before touching any other surface or items.<br><br>On May 4, 2022, at approximately 8:25 a.m., DON-C stated she expected staff to remove gloves and perform hand hygiene after completing the blood glucose test and before touching anything.<br><br>The licensee's Hand Hygiene policy, copyright 2022, directed handwashing should be performed | 0 510 | | |

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| 0 510 | Continued From page 8<br>after removing gloves.<br><br>The licensee's Disposal of Contaminated Material and Equipment policy, copyright 2022, directed any disposable equipment that is sharp, such as lancets, needles, syringes, razor blades, must be disposed of in the client's sharps container and or community provided sharps container; however, the policy did not include safety with transporting sharps.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 640 SS=F | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected | 0 640 | | |

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| 0 640 | Continued From page 9 | 0 640 | | |

vulnerable adult maltreatment as required. This had the potential to affect all of the licensee's current residents, staff, and visitors.

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

The findings include:

The licensee failed to:
- post the 911 emergency number in common areas and near telephones provided by the assisted living facility.

During a facility tour on May 2, 2022, at 1:40 p.m., with director of nursing (DON)-C the surveyor observed the entry area, common areas, and medication rooms within the facility, and noted there was no posting of the 911 emergency number, as required.

On May 6, 2022, at approximately 1:23 p.m., licensed assisted living director (LALD)-A stated each household had a telephone and included the 911 emergency number.

During an observation on May 6, 2022, at approximately 1:45 p.m., the surveyor observed the common areas on the first and second floors within the facility and near telephones provided by the licensee. Each of the two households on the second floor, Living Waters and Sunrise, had a desk type telephone on the counter. A small white

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| 0 640 | Continued From page 10<br>sticker was attached on the top upper edge of the telephone that included, "Emergency 911." However, one telephone located on the counter of the first floor Driftwood household lacked the posting of the 911 emergency number. There was no telephone observed in the Cliff Rock household, and no posting of the 911 emergency number.<br><br>On May 6, 2022, at approximately 1:50 p.m., licensed practical nurse (LPN)-J stated he was not aware of any postings of the 911 emergency number.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days. | 0 640 | | |
| 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 | 0 680 | | |

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| 0 680 | Continued From page 11<br>disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with the required content. This had the potential to affect all residents receiving services under the assisted living license, 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, 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>During the entrance conference on May 2, 2022, at approximately 1:06 p.m., the surveyor requested the licensee's emergency preparedness plan and Appendix Z.<br><br>During the initial tour on May 2, 2022, at approximately 1:32 p.m., the surveyor observed the facility's layout included one building with two floors of resident areas. The first floor was a | 0 680 | | |

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| 0 680 | Continued From page 12<br>locked dementia care unit.<br><br>A review of the provided documents lacked evidence of:<br>- a policy/procedure to address sewage and waste disposal; and<br>- participation in an annual full-scale exercise.<br><br>On May 4, 2022, at approximately 2:49 p.m., licensed assisted living director (LALD)-A confirmed the licensee lacked a sewage/waste disposal policy, and stated the last table-top exercise was done February 2020.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 680 | | |
| 0 730 SS=D | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, | 0 730 | | |

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| 0 730 | Continued From page 13 | 0 730 | | |

guardianships, powers of attorney, or conservatorships;
(7) the facility's current and previous assessments and service plans;
(8) all records of communications pertinent to the resident's services;
(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;
(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;
(11) documentation that services have been provided as identified in the service plan;
(12) documentation that the resident has received and reviewed the assisted living bill of rights;
(13) documentation of complaints received and any resolution;
(14) a discharge summary, including service termination notice and related documentation, when applicable; and
(15) other documentation required under this chapter and relevant to the resident's services or status.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R5) with record reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a

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| 0 730 | Continued From page 14<br>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>R5's record lacked a discharge summary to include:<br>- diagnoses;<br>- course of illness;<br>- allergies;<br>- treatments and therapies;<br>- pertinent lab, radiology, and consultation results; and<br>- a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status.<br><br>R5's diagnoses included dementia.<br><br>R5 began receiving services on November 22, 2016, and was discharged on December 2, 2021.<br><br>R5's Discharge Summary dated December 2, 2022, noted the reason for initiation of services included dementia care and repeated falls, and the summary of services provided during the course of services included all activities of daily living and medication supervision but lacked the above required content.<br><br>On May 6, 2022, at approximately 1:00 p.m., housing director (HD)-D stated what was included in the discharge summary is all that had been done and acknowledged it lacked the required content. | 0 730 | | |

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| 0 730 | Continued From page 15<br><br>The licensee's Discharge Summary policy dated March 3, 2022, noted the discharge summary would include a summary of the resident's stay including diagnosis, course of illnesses, allergies, treatments, therapies, pertinent lab results, radiology results, and consultation results, and a final summary of the resident's status.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTIONS:<br>Twenty-one (21) days | 0 730 | | |
| 01440 SS=D | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.<br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not | 01440 | | |

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| 01440 | Continued From page 16<br>performed delegated tasks for one year or longer.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of two unlicensed personnel (ULP)-F with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-F was hired on December 13, 2021, to provide direct care services to residents of the licensee.<br><br>ULP-F's record lacked evidence of the required supervision within 30 days of hire performing delegated tasks.<br><br>On May 6, 2022, at approximately 10:35 a.m., housing director (HD)-D confirmed ULP-F's record lacked evidence of the required supervision.<br><br>The licensee's Supervision of Unlicensed Personnel policy dated March 3, 2022, noted direct supervision of ULP providing delegated nursing tasks must be performed within 30 days | 01440 | | |

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| 01440 | Continued From page 17<br>after the person began working for the community and had been trained and determined competent in performing assigned tasks.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01440 | | |
| 01470 SS=F | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<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 | 01470 | | |

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| 01470 | Continued From page 18<br><br>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:<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 staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (registered nurse (RN)-B, unlicensed personnel (ULP)-F, ULP-G) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 01470 | | |

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| 01470 | Continued From page 19<br>safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>RN-B, ULP-F, and ULP-G's records lacked orientation to include:<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>RN-B was hired on March 18, 2019, and began providing assisted living services for the licensee on August 1, 2021.<br><br>ULP-F was hired and began providing assisted living services for the licensee on December 13, 2021.<br><br>ULP-G was hired on June 16, 2015, and began providing assisted living services for the licensee on August 1, 2021.<br><br>On May 4, 2022, at approximately 2:00 p.m., licensed assisted living director (LALD)-A confirmed none of the employees had received an introduction and review of the facility's policies and procedures related to the provision of assisted living services.<br><br>The licensee's Additional Orientation for AL (assisted living) Nursing Associates, effective August 1, 2021, directed associates providing and supervising nursing services would complete an orientation to Assisted Living licensure | 01470 | | |

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| 01470 | Continued From page 20<br>requirements and regulations before providing services to residents, including but not limited to, an introduction and review of policies and procedures related to the provision of assisted living services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01470 | | |
| 01540 SS=D | 144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED<br><br>(3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure staff completed the required amount of dementia care training in the required time frame for one of three employees | 01540 | | |

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| 01540 | Continued From page 21<br>(unlicensed personnel (ULP)-F) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2021.<br><br>ULP-F was hired on December 13, 2021, to provide direct care services to residents of the licensee.<br><br>ULP-F's employee record contained evidence of 2.5 hours training on dementia care topics within 80 hours of the start date. ULP-F reached 80 working hours on January 7, 2022. ULP-F's record had evidence of an additional 2.5 hours training on dementia care topics on March 28, 2022.<br><br>On May 6, 2022, housing director (HD)-D verified ULP-F lacked the required 8 hours of dementia training with 80 working hours.<br><br>The licensee's undated Dementia Disclosure: Specialized Memory Care Community form noted dementia training would be provided to all direct care staff and their supervisors but lacked the amount of training or frequency. | 01540 | | |

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| 01540 | Continued From page 22<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01540 | | |
| 01620 SS=E | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) assessed two of two residents (R2, R4) with falls, for causative factors | 01620 | | |

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| 01620 | Continued From page 23 | 01620 | | |

to determine individualized interventions to reduce the resident's risk for injury and failed to ensure the RN completed a comprehensive reassessment no more than 14 days after the initiation of services, for one of four residents (R4) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

ASSESSMENTS WITH FALLS
R2
R2's diagnoses included Alzheimer's disease and Lewy Body dementia.

On May 3, 2022, at approximately 9:00 a.m., the surveyor observed R2 in his bed on his left side, R2 appeared to be asleep.

R2's Service Plan With Schedule effective April 29, 2022, noted services including assistance with activities of daily living (ADL), medication management and diabetic management.

R2's Resident Evaluation for [R2], Marywood AL/IL dated April 29, 2022, indicated R2 had occasional falls (3-6 times per year), directing "Resident needs to be reminded to not transfer to his WC [wheelchair] ind [independently] in his room. Keep chair at a safe distance so that resident does not self transfer. Report increasing

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| 01620 | Continued From page 24<br>evidence of unsteadiness or other safety concerns."<br><br>R2's Notes and Resident Occurrence Management Project (ROMP) revealed R2 had multiple falls as noted below. Director of nursing (DON)-C and housing director (HD)-D were interviewed on May 6, 2022, at approximately 12:20 p.m., with response to each fall noted below.<br>- January 26, 2022, at 9:00 p.m., staff found R2 on the floor on his stomach at the end of his bed with an abrasion to the right side of his forehead and a skin tear to the right forearm. Staff sent R2 out to the emergency department for evaluation. The RN did not complete a falls risk form, which the licensee identified as the falls assessment, after the fall. DON-C stated the ROMP notes were "a little bit sparse."<br>- March 11, 2022, at 9:50 p.m., staff found R2 on the floor on his side in the rocker glider. Staff indicated they thought R2 maybe tripped when trying to get up. No injuries were noted. The chair was removed for safety. The RN did not complete a fall risk or make changes to R2's plan of care other than removing the chair.<br>- March 17, 2022, at 1:15 a.m., staff found R2 on the floor next to his bed. R2 had a skin tear on the right elbow. A completed fall report indicated R2 had been sitting in his recliner prior to the fall, with interventions noted "Service plan reviewed, and no changes made" and "Dressed skin tear."<br>- March 20, 2022, at 4:15 p.m., staff found R2 on the floor next to his bed. R2 said he hit his head. R2's wife requested bedrails for more stability when getting out of bed. The writer noted R2 does not remember to call for help and self-transfers. The RN did not complete a falls risk form and did not put any new interventions in place. | 01620 | | |

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| 01620 | Continued From page 25<br>- March 29, 2022, at 7:00 p.m., staff found R2 on the floor in his room, in front of the door on his right side. Staff brought R2 to the bathroom as he was incontinent of bowel. The RN did not complete a falls risk form but noted for staff to ensure call light was within reach and to ensure R2's bed was in a low position.<br>- April 11, 2022, at 5:00 p.m., staff noted R2 lost balance and was assisted to the ground by staff in his room. R2 hit head on staff's knee on the way down. No injury noted. Interventions were to remove chairs other than the recliner as he had falls from the other chairs. Hospice put in a referral to occupational therapy (OT). DON-C stated she had called OT last week and was told they were short staffed and would get someone out as soon as they could. DON-C confirmed the RN did not complete a falls risk form.<br>- April 28, 2022, at 8:45 p.m., staff found R2 on the floor next to his bed. R2 was incontinent of bowel. No injuries were noted but staff did note R2 was combative. Interventions were more frequent checks, be sure call light is in reach, and offer bathroom every two hours. Fall risk form completed, which indicated a total score of 16. The form incorrectly noted one or two falls in the last six months. Plan of action to be taken noted plan of care updated. No new interventions were implemented.<br>- May 1, 2022, at 3:00 a.m., staff found R2 on the floor in the bathroom. No injury noted. R2 was incontinent of bowel. Interventions noted were to increase monitoring and ensure R2's call light was in reach.<br>DON-C stated everyone is on every 2-hour checks. DON-C stated the process following a fall included competion of the ROMP, investigation and then putting in place any interventions if needed. DON-C stated a falls risk/assessment should be completed after each fall, and verified | 01620 | | |

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nursing had not completed one with all of R2's falls. In addition, R2's service plan was not updated to include every 2-hour toileting, and R2's safety checks remained at every 2 hours.
R4
R4's Resident Evaluation for [R4], Marywood AL/IL, dated February 8, 2022, indicated R4 was alert and able to communicate needs to staff. Also included, R4 had frequent falls related to weakness with hospitalization prior to admission, used assistive devices including manual wheelchair and walker for general mobility, and had occasional falls (3 to 6 times per year), directing "Report increasing evidence of unsteadiness or other safety concerns. Report all falls and any increase in falls or other safety concerns."

R4's Notes and ROMP revealed R4 had two (2) falls, on March 1, 2022, and April 13, 2022. R4's record lacked evidence the RN completed an assessment to assess for causative factors to determine individualized interventions to reduce the resident's risk for injury.

R4's ROMP forms and Notes revealed the following:
- March 1, 2022, at 6:41 a.m., resident note (written by RN-B) indicated R4 was getting ready for dialysis and "he was shuffling over to his w/c [wheelchair] he said and his knees just gave out." R4 fell to his knees and then his buttocks, denied hitting his head or his "shunt arm" and had been given two hydrocodone (pain medication) approximately 30 minutes before the fall. ROMP documentation indicated no apparent injury, and root cause was identified as "endurance."
- April 13, 2022, at 11:45 p.m., ROMP documentation indicated staff found R4 on his abdomen, on the floor near the radiator. Two staff

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assisted to get him up. R4 denied hitting his head and was noted to have abrasions on bilateral knees and right inner aspect of the ankle. While interviewing R4, he tried to get up and walk with unstable gait, refused his walker, was confused, restless and fidgety. R4 was transported to the emergency department and returned with no findings. Root cause was identified as "Altered Gait/Balance" and "Endurance."

R4's record lacked evidence the RN completed a re-evaluation to determine individualized interventions to reduce the resident's risk for injury.

On May 6, 2022, at approximately 12:02 p.m., DON-C stated, "We do an investigation and then do interventions and change things if needed." DON-C stated they discussed residents' falls at IDT (interdisciplinary team) meetings and "try different things," but stated that wasn't always documented.

On May 6, 2022, at approximately 1:18 p.m., DON-C indicated a falls risk assessment should have been completed after each fall; however, were not completed after each of R4's falls, therefore, no new interventions were implemented.

The licensee's BHS (Benedictine Health System) Fall Prevention and Reduction policy, dated August 1, 2021, indicated appropriate interventions would be implemented as needed to maintain resident safety, prevent falls and reduce injury from falls. In addition, the policy indicated falls would be investigated to identify the potential root cause in accordance with the ROMP, the RN would review the service plan and make changes as needed and implement new interventions in

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the agreement with the resident/resident representative.

14-DAY ASSESSMENT

R4
R4 was admitted for services on March 21, 2022.

R4's diagnoses included encephalopathy and end stage renal disease with dialysis, abnormality of gait and mobility and weakness.

R4's Service Plan With Schedule, dated March 9, 2022, indicated R4 received services which included supervision with dressing and grooming, showering, assist of one with all transfers, medication administration, diabetic management, and laundry and housekeeping services.

On May 3, 2022, at approximately 11:00 a.m., the surveyor observed unlicensed personnel (ULP)-G use a sensor to complete R4's blood glucose check.

R4's record included documentation titled, Resident Evaluation for [R4], Marywood AL (assisted living)/IL (independent living), dated February 24, 2022, intended to be the 14-day assessment, was completed 16 calendar days after the initiation of services, instead of no more than 14 calendar days after initiation of services, as required.

On May 6, 2022, at approximately 12:10 p.m., DON-C and HD-D confirmed the 14-day reassessment for R4 was not conducted within 14 calendars after initiation of services.

The licensee's Initial and On-Going Assessments of Residents policy dated August 1, 2021, noted

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| 01620 | Continued From page 29<br>the RN would complete a 14-day assessment, to be completed up to 14 days after the start of services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the | 01640 | | |

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licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of four residents (R1) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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's diagnoses included diabetes type II and ataxia (uncoordinated abnormal movements).

R1's Service Plan with Schedule dated effective May 2, 2022, noted services including assistance with transfers, medication management and diabetic management. However, the service plan lacked a signature or other authentication by the facility and the resident/resident's representative, documenting agreement on the services to be provided.

On May 6, 2022, at approximately 10:25 a.m., housing director (HD)-D stated the resident evaluation had been signed by the resident and his representative, as well as the facility, but not the service plan.

The licensee's Service Plan policy dated August 1, 2021, noted the service plan and any revision must include a signature or other authentication by the facility and by the resident/resident's representative documenting agreement on the

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| 01640 | Continued From page 31<br>services to be provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |
| 01700 SS=F | 144G.71 Subd. 2 Provision of medication management services<br><br>(a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.<br>(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. | 01700 | | |

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| 01700 | Continued From page 32<br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment with the required content for four of four residents (R1, R2, R3 and R4) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>During the entrance conference on May 2, 2022, at approximately 1:06 p.m., licensed assisted living director (LALD)-A and director of nursing (DON)-C stated the licensee provided medication management services to the licensee's residents.<br><br>R1, R2, R3 and R4's records lacked evidence the RN had conducted a medication assessment to include:<br>- indications for medications; and<br>- allergic or adverse reactions and actions to address those issues.<br><br>R1<br>R1's diagnoses included diabetes type II and ataxia (uncoordinated abnormal movements).<br><br>R1's prescriber orders dated April 11, 2022, included one pain reliever and one oral diabetes medication. | 01700 | | |

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| 01700 | Continued From page 33<br><br>R1's April 2022 Medication Administration Record (MAR) listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given.<br><br>R1's Service Plan With Schedule dated effective May 2, 2022, noted services including assistance with transfers, medication management and diabetic management.<br><br>R1's Medication Management Assessment dated May 2, 2022, indicated, "All medications known and possible side effects or contraindications have been discussed with client or client's representative and name of person notified." However, the assessment lacked the above required content.<br><br>On May 6, 2022, at approximately 10:25 a.m., DON-C confirmed R1's record lacked the required content in the medication assessment.<br><br>R2<br>R2's diagnoses included Alzheimer's disease and Lewy Body dementia.<br><br>R2's prescriber orders dated April 6, 2021, included one antidepressant and one pain reliever.<br><br>R2's April 2022 MAR listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given.<br><br>R2's Service Plan With Schedule effective April 29, 2022, noted services including assistance with activities of daily living (ADL), medication management and diabetic management. | 01700 | | |

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| 01700 | Continued From page 34<br><br>R2's Medication Management Assessment dated February 4, 2022, noted "All medications known and possible side effects or contraindications have been discussed with client or client's representative and name of person notified." However, the assessment lacked the above required content.<br><br>On May 6, 2022, at approximately 11:00 a.m., DON-C confirmed R2's record lacked the required content in the medication assessment. In addition, DON-C verified the same medication assessment was utilized for all residents.<br>R3<br>R3's diagnoses included mild cognitive impairment, weakness, malaise and difficulty in walking.<br><br>R3's last signed prescriber orders, dated April 6, 2021, included one pain reliever, an antidepressant, five supplements, one medication to decrease fluid, and two medications to help prevent urinary tract infection.<br><br>R3's April 2022 MAR listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given.<br><br>R3's Service Plan With Schedule, dated May 3, 2022, indicated R3 received services including assistance with activities of daily living (ADL), transfers with assistance of two and mechanical lift, extensive assistance with eating, laundry and housekeeping services and medication management.<br><br>R3's Medication Management Assessment, dated May 2, 2022, indicated "All medications known and possible side effects or contraindications have been discussed with client or client's | 01700 | | |

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| 01700 | Continued From page 35<br>representative and name of person notified;" however, the assessment lacked the above required content.<br><br>On May 6, 2022, at approximately 11:00 a.m., DON-C confirmed R3's record lacked the required content in the medication assessment. In addition, DON-C verified the same medication assessment was utilized for all residents.<br><br>R4<br>R4's diagnoses included encephalopathy and end stage renal disease with dialysis, abnormality of gait and mobility and weakness.<br><br>R4's prescriber orders, dated February 7, 2022, included two insulins, one gout medication, one blood pressure medication, one cholesterol medication, one allergy medication, and two supplements.<br><br>R4's April 2022 MAR listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given.<br><br>R4's Service Plan With Schedule, dated March 9, 2022, indicated R4 received services which included supervision with dressing and grooming, showering, assist of one with all transfers, medication administration, diabetic management, and laundry and housekeeping services.<br><br>R4's Medication Management Assessment, dated February 8, 2022, indicated "All medications known and possible side effects or contraindications have been discussed with client or client's representative and name of person notified;" however, the assessment lacked the above required content. | 01700 | | |

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| 01700 | Continued From page 36<br><br>On May 6, 2022, at approximately 11:00 a.m., DON-C confirmed R4's record lacked the required content in the medication assessment. In addition, DON-C verified the same medication assessment was utilized for all residents.<br><br>The licensee's Medication Management policy dated August 1, 2021, noted the medication assessment would include indications for use and allergic or adverse reactions and actions to address those issues.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01700 | | |
| 01730 SS=F | 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 | 01730 | | |

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| 01730 | Continued From page 37<br>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 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 interview and record review, the licensee failed to develop an individualized medication management record with the required content for four of four residents (R1, R2, R3 and R4) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). | 01730 | | |

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| 01730 | Continued From page 38<br><br>The findings include:<br><br>R1, R2, R3 and R4's records lacked evidence of a medication management plan to include:<br>- a description of storage of medications based on resident's needs and preferences; and<br>- identification of medication management tasks that may be delegated to unlicensed personnel.<br><br>During the entrance conference on May 2, 2022, at approximately 1:06 p.m., licensed assisted living director (LALD)-A and director of nursing (DON)-C stated the licensee provided medication management services to the licensee's residents.<br><br>R1<br>R1's diagnoses included diabetes type II and ataxia (uncoordinated abnormal movements).<br><br>R1's prescriber orders dated April 11, 2022, included one pain reliever and one oral diabetes medication.<br><br>R1's April 2022 Medication Administration Record (MAR) listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given.<br><br>R1's Service Plan With Schedule dated effective May 2, 2022, noted services including assistance with transfers, medication management and diabetic management.<br><br>R1's Medication Management Assessment dated May 2, 2022, noted staff administer medications for the resident and the licensed nurse orders refills. However, the assessment lacked the above required content. | 01730 | | |

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| 01730 | Continued From page 39<br>On May 6, 2022, at approximately 10:25 a.m., DON-C confirmed R1's record lacked the required content in the medication management plan, which was a part of the service plan. In addition, DON-C verified the same format was utilized for all residents.<br><br>R2<br>R2's diagnoses included Alzheimer's disease and Lewy Body dementia.<br><br>R2's prescriber orders dated April 6, 2021, included one antidepressant and one pain reliever.<br><br>R2's April 2022 MAR listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given.<br><br>R2's Service Plan With Schedule effective April 29, 2022, noted services including assistance with activities of daily living (ADL), medication management and diabetic management.<br><br>R2's Medication Management Assessment dated February 4, 2022, noted staff administer medications for the resident and the licensed nurse orders refills. However, the assessment lacked the above required content.<br><br>On May 6, 2022, at approximately 11:00 a.m., DON-C confirmed R2's record lacked the required content in the medication assessment. In addition, DON-C verified the same medication assessment was utilized for all residents.<br>R3's diagnoses included mild cognitive impairment, weakness, malaise, and difficulty in walking.<br><br>R3's last signed prescriber orders, dated April 6, | 01730 | | |

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| 01730 | Continued From page 40 | 01730 | | |

2021, included one pain reliever, an antidepressant, five supplements, one medication to decrease fluid, and two medications to help prevent urinary tract infection.

R3's April 2022 MAR listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given.

R3's Service Plan With Schedule, dated May 3, 2022, indicated R3 received services including assistance with activities of daily living (ADL), transfers with assistance of two and mechanical lift, extensive assistance with eating, laundry and housekeeping services, and medication management.

R3's Medication Management Assessment, dated May 2, 2022, indicated staff administer medications for the resident and the licensed nurse orders refills; however, the assessment lacked the above required content.

On May 6, 2022, at approximately 10:25 a.m., DON-C confirmed R3's record lacked the required content in the medication management plan, which was a part of the service plan. In addition, DON-C verified the same format was utilized for all residents.

R4
R4's diagnoses included encephalopathy and end stage renal disease with dialysis, abnormality of gait and mobility and weakness.

R4's prescriber orders, dated February 7, 2022, included two insulins, one gout medication, one blood pressure medication, one cholesterol medication, one allergy medication, and two supplements.

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| 01730 | Continued From page 41<br><br>R4's April 2022 MAR listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given.<br><br>R4's Service Plan With Schedule, dated March 9, 2022, indicated R4 received services which included supervision with dressing and grooming, showering, assist of one with all transfers, medication administration, diabetic management, and laundry and housekeeping services.<br><br>R4's Medication Management Assessment, dated February 8, 2022, indicated staff administer medications for the resident and the licensed nurse orders refills; however, the assessment lacked the above required content.<br><br>On May 6, 2022, at approximately 10:25 a.m., DON-C confirmed R4's record lacked the required content in the medication management plan, which was a part of the service plan. In addition, DON-C verified the same format was utilized for all residents.<br><br>The licensee's Medication Management policy dated August 1, 2021, noted the RN would develop and maintain a current individualized medication management record to include a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions, and identification f the medication management tasks that could be delegated to the unlicensed personnel.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |

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| 01750 SS=D | 144G.71 Subd. 7 Delegation of medication administration<br><br>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:<br>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and<br>(3) communicated with the unlicensed personnel about the individual needs of the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure as needed (PRN) medications had parameters for administration for one of four residents (R1) with records reviewed.<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 specific written instructions regarding the administration of PRN medication ordered. | 01750 | | |

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| 01750 | Continued From page 43<br><br>R1's diagnoses included diabetes type II and ataxia (uncoordinated abnormal movements).<br><br>R1's prescriber orders dated April 11, 2022, included:<br>- "Acetaminophen Tablet 325 MG [milligrams] Give 1 tablet by mouth every 6 hours as needed for Pain (325mg)***NTE [not to exceed] 4000mg in 24 hours from all sources***"; and<br>- "Acetaminophen Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for Pain (650mg)***NTE 4000mg in 24 hours from all sources***."<br><br>R1's Service Plan With Schedule dated effective May 2, 2022, noted services including assistance with transfers, medication management and diabetic management.<br><br>On May 6, 2022, at approximately 10:25 a.m., director of nursing (DON)-C was unable to state which order was to be used and when, and stated "It could be clearer."<br><br>The licensee's Medication Administration - PRN Usage policy dated August 1, 2021, noted the registered nurse (RN) would review the PRN prescriptions to ensure they clearly identified the medication name, symptoms for which it was prescribed, frequency it may be administered, dose that may be administered, route that should be used, when to notify the RN, requirements for following up on PRN administration, and any other pertinent information needed to ensure proper administration.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01750 | | |

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| 01760 SS=E | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for one of four residents (R3) with records reviewed. In addition, the licensee failed to ensure insulin was administered per the manufacturer's instructions for two of two residents (R8, R9) observed during insulin administration.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). | 01760 | | |

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| 01760 | Continued From page 45<br>The findings include:<br><br>MEDICATIONS AS PRESCRIBED<br><br>R3's diagnoses included mild cognitive impairment, weakness, malaise, and difficulty in walking.<br><br>R3's Service Plan With Schedule, dated May 3, 2022, indicated R3 received services including assistance with activities of daily living (ADL), transfers with assistance of two and mechanical lift, extensive assistance with eating, laundry and housekeeping services and medication management.<br><br>R3's Medication Management Assessment, dated May 2, 2022, indicated R3 received medication services and the licensed nurse managed handling changes to prescriptions or orders, communications with pharmacy and prescribers, and ordered all medications.<br><br>R3's last signed prescriber orders, dated April 6, 2021, included an order for acetaminophen (pain reliever) 160 milligrams (mg)/5 milliliters (ml), take 20.3 ml orally every four hours as needed for pain/fever; however, the unsigned Physician Order Report printed May 3, 2022, included an order for acetaminophen 160 mg/5 ml, give 20 ml orally four times a day, while awake, for pain. In addition, R3's signed orders from April 6, 2021, and unsigned orders printed May 3, 2022, included an order for albuterol sulfate (relieves muscle tightening in the airways) 2.5 mg/3 ml one vial via nebulizer every four hours as needed for shortness of breath (SOB) or cough, with special instructions to give every six hours.<br><br>R3's Medication Administration Record (MAR), | 01760 | | |

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dated April 1, 2022, through April 30, 2022, indicated the acetaminophen scheduled for 7:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m., was "Not Administered: Drug/Item Unavailable" from April 3, 2022, 4:00 p.m. dose through April 11, 2022, 7:00 a.m. dose, or 31 doses, and from April 25, 2022, 7:00 a.m. through May 2, 2022, 12:00 p.m., or 26 doses. In addition, the April and May MARs included albuterol sulfate 2.5 mg/3 ml one vial, with frequency every six hours as needed, with special instructions to give one vial via nebulizer every four hours as needed for SOB or cough.

On May 6, 2022, at approximately 12:02 p.m., director of nursing (DON)-C verified the above information and stated weekly monitoring was completed by the nurses and she would need to talk to licensed practical nurse (LPN)-J because he signed off indicating he reviewed R3's medication administration record. DON-C stated she didn't know why the acetaminophen was not given, and indicated she was not aware of the discrepancy with the frequency of administration for the albuterol order.

On May 6, 2022, at approximately 1:30 p.m., LPN-J stated he doesn't review medication administration. LPN-J stated R3's family supplied her acetaminophen but was not sure why she was without the medication for so long. LPN-J indicated there was no process in place for ensuring the family had been notified of the need for the medication, therefore, staff would assume that the previous staff had notified the family, but that wasn't always the case. LPN-J stated he had no idea what happened with this situation and why she was without the medication so long.

INSULIN ADMINISTRATION

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| 01760 | Continued From page 47<br><br>R8<br>R8's diagnoses included type II diabetes, muscle weakness, and history of falling.<br><br>R8's Service Plan With Schedule, dated May 5, 2022, indicated R8 required assistance with storage and preparation of scheduled insulin, monitoring/adjustment of sliding scale insulin based on blood glucose check and staff administer insulin four times each day.<br><br>R8's prescriber orders, dated November 15, 2021, included blood glucose checks and aspart (short acting, same as Novolog) insulin before meals and at bedtime, per sliding scale.<br><br>On May 3, 2022, at approximately 11:09 a.m., the surveyor observed registered nurse (RN)-B prepare to administer R8's insulin. RN-B wheeled R8 into his room, unlocked the cupboard where the medications and insulin were stored and removed the insulin. RN-B stated that she needed to go to get her tablet to ensure the amount of insulin and left the room. At 11:20 a.m., RN-B returned to the room, dialed the Novolog FlexPen to one (1) unit, pushed the end of the pen, and then dialed to four (4) units. RN-B donned gloves, attempted to verify dose on the tablet but couldn't bring up the information, opened the cupboard to verify the dose on a printed piece of paper with the sliding scale, and administered the insulin to R8's abdomen.<br><br>R9<br>R9's diagnoses included type II diabetes with diabetic kidney complication, dementia with behavioral disturbance, and heart disease.<br><br>R9's Service Plan With Schedule, dated May 9, | 01760 | | |

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2022, indicated R9 "Needs assistance with storage, preparation, set-up, or blood sugar checks only and then resident is able to administer insulin on own or with cues or set up," twice daily.

R9's prescriber orders, dated July 26, 2021, included checking blood glucose two times daily, before breakfast and before supper, and included the following insulin orders:
- Lantus Solostar (long acting) U-100 Insulin 40 units subcutaneous with breakfast; and
- Novolin N Flexpen (short acting, same as aspart and Novolog) 6 units subcutaneous with supper.
Additional prescriber orders, dated November 9, 2021, directed to increase Lantus to 44 units daily, and to change aspart insulin to 8 units at noon and supper. No additional orders were provided by the licensee.

R9's Nurse Only Administration History, dated May 1, 2022, through May 9, 2022, included in addition to the above orders, aspart insulin to be administered per sliding scale before meals. The information provided to the surveyors did not include this order.

On May 3, 2022, at approximately 11:29 a.m., RN-B stated she needed to administer R9's insulin prior to an outing for lunch. RN-B stated she verified the dose according to R9's blood sugar obtained by the unlicensed personnel (ULP) and retrieved R9's Novolog insulin pen from his room. RN-B stated she needed to "prime" the pen with "one [1] unit" while the surveyor observed, and then dialed the insulin pen to administer two (2) units. RN-B retreived gloves from a drawer near the kitchen, donned the gloves, and walked outside to an awaiting bus loaded with residents for the outing. RN-B asked

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accompanying staff to remove R9 from the bus so that she could give his insulin. Staff removed R9 from the bus and wheeled R9 into the entry way of the building. RN-B administered R9's insulin into his abdomen and alerted staff that she was finished.

During an interview on May 3, 2022, at approximately 2:38 p.m., RN-B stated she always primed the insulin needle by dialing to one unit, pushing the plunger, and then dialed the prescribed dose. RN-B stated she wasn't sure what the licensee's policy directed, and stated she wasn't aware of the manufacturer's instructions for priming the insulin needle.

On May 4, 2022, at approximately 8:24 a.m., DON-C stated she was unable to find a policy for insulin administration; however, she stated she had a leaflet with the manufacturer's instructions posted in the medication room. DON-C stated she expected staff to follow the manufacturer's instructions to prime the needle with two units prior to administering the prescribed dose.

The manufacturer's instructions for the use of Novolog insulin FlexPens, dated October 2021, directed for the insulin pen to be primed with two units prior to dialing the prescribed dosage to avoid injecting air and to ensure proper dosing.

The licensee's Medication Management policy, effective August 1, 2021, indicated the RN would develop and maintain a current individualized medication management record that would contain identification of persons responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis. In addition, the policy indicated the medication management record would contain any

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| 01760 | Continued From page 50<br>resident-specific requirements relating to documenting medication administration, verifications that all medications were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 01830 SS=E | 144G.71 Subd. 14 Renewal of prescriptions<br><br>Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to renew prescriptions at least every 12 months for two of four residents (R3 and R2) with records reviewed.<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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include: | 01830 | | |

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| 01830 | Continued From page 51<br>R3 and R2's records lacked an annual renewal of prescriber orders for medications.<br><br>R3<br>R3's diagnoses included mild cognitive impairment, weakness, malaise, and difficulty in walking.<br><br>R3's Medication Management Assessment, dated May 2, 2022, indicated R3 received medication services and the licensed nurse managed handling changes to prescriptions or orders, communications with pharmacy and prescribers, and ordered all medications.<br><br>R3's prescriber orders, dated April 6, 2021, included the following medications:<br>- Azo-Cranberry (reduces risk for urinary tract infections) 250 mg po (by mouth) twice daily;<br>- Bayer chewable aspirin (prevent heart attack/pain) 81 mg po daily;<br>- Cerovite Advanced Formula (supplement) 18-400 mg-mcg (micrograms) po daily;<br>- Cymbalta (treat depression/anxiety) delayed release 30 mg po daily;<br>- gabapentin (prevent seizures/relieve nerve pain) 300 mg po three times daily;<br>- gabapentin 600 mg po at bedtime;<br>- levothyroxine (treat underactive thyroid) 25 mcg po daily;<br>- omeprazole 40 mg po twice daily before breakfast and supper;<br>- Os-Cal (supplement) 500 + D3 500 mg-200 unit po daily;<br>- Systane (eye lubricant) 0.4-0.3 % 1-2 drops each eye at bedtime;<br>- vitamin D3 (supplement) 2000 units po daily;<br>- Floranex (aids in digestion) 1 million cell po daily;<br>- Lipo-Flavonoid Plus (treats ringing in ears) | 01830 | | |

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| 01830 | Continued From page 52<br><br>200-100 mg po daily;<br>- Miralax (treat constipation) 17 gram po as needed;<br>- ProAir HFA (inhaler) (prevent/treat wheezing) 90 mcg one puff every 4 hours as needed;<br>- acetaminophen (pain) 160 mg/5 ml (milliliters) give 20.3 ml every four hours as needed;<br>- miconazole nitrate 2% (treats fungal infection) one application topically as needed;<br>- Premarin cream (treats symptoms of menopause) 0.625 mg/gram vaginally at bedtime on Monday, Wednesday, Friday; and<br>- albuterol sulfate (relaxes muscles in airway) 2.5 mg/3 ml one vial inhalation via nebulizer every four hours as needed (sic) every six hours.<br><br>R3's Service Plan With Schedule, dated May 3, 2022, indicated R3 received services including assistance with ADL (activities of daily living), transfers with assistance of two and mechanical lift, extensive assistance with eating, laundry and housekeeping services and medication management.<br><br>R3's April 2022 MAR listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given.<br><br>On May 6, 2022, at approximately 11:00 a.m., director of nursing (DON)-C confirmed R3's prescriber orders had not been renewed since April 6, 2021, and should be updated annually. DON-C stated the electronic medical record indicated R3 was due for annual review in June 2022, but stated should have been done in April 2022.<br><br>R2<br>R2's diagnoses included Alzheimer's disease and Lewy Body dementia. | 01830 | | |

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| 01830 | Continued From page 53<br><br>R2's Medication Management Assessment dated February 4, 2022, noted staff administer medications for the resident.<br><br>R2's prescriber orders dated April 6, 2021, included the following medications:<br>- acetaminophen 650 mg po every 4 hours as needed (prn) for pain or fever not to exceed 3000 mg per day;<br>- allopurinol (treat gout) 300 mg po every morning (q am);<br>- aspirin (prevent heart attack/pain) 81 mg po every day (qd);<br>- venlafaxine (antidepressant) 75 mg po qd;<br>- tamsulosin (treat enlarged prostate) 0.4 mg po qd;<br>- atorvastatin (treat high cholesterol levels) 40 mg po qd;<br>- memantine (treat dementia associated with Alzheimer's disease) 5 mg po q am;<br>- omeprazole (treat heartburn) 40 mg po qd;<br>-quetiapine (treat depression and bipolar disorder) 50 mg po q bedtime (hs);<br>- donepezil (treat Alzheimer's disease) 5 mg po qd; acetaminophen 650 mg po q hs;<br>- sennosides-docusate sodium (to reduce constipation) 8.6-50 mg 1 tab po q am;<br>- quetiapine 25 mg po twice a day (bid);<br>- glucagon hcl solution (to treat very low blood sugar) 1 mg as needed; and<br>- Lantus SoloStar (treat diabetes) 20 units subcutaneous (sq) qd.<br><br>R2's Service Plan With Schedule effective April 29, 2022, noted services including assistance with ADL's, medication management and diabetic management.<br><br>R2's April 2022 Medication Administration Record | 01830 | | |

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| 01830 | Continued From page 54<br>(MAR) listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given.<br><br>On May 6, 2022, at approximately 11:00 a.m., DON-C confirmed R2's prescriber orders had not been renewed since April 6, 2021, and should be updated annually. In addition, DON-C stated they had a process to remind them when the orders were due, but something must have gone wrong.<br><br>The licensee's Medication & Treatment Orders - Receiving, Implementing, Renewal and Re-ordering policy dated August 1, 2021, noted medication orders would be sent to the authorized provider for signature at least every 12 months.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01830 | | |
| 01880 SS=D | 144G.71 Subd. 19 Storage of medications<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted only authorized personnel access, for one of three medication storage cupboards (R2's room) during observation of medication storage. | 01880 | | |

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| 01880 | Continued From page 55 | 01880 | | |

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:

During the entrance conference on May 2, 2022, at approximately 1:06 p.m., licensed assisted living director (LALD)-A and housing director (HD)-D verified the licensee had a locked dementia care unit on the first floor, and high acuity residents with dementia on the second floor.

The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 48 residents, with a locked dementia care unit on the first floor, and high acuity residents with dementia on the second floor. Each resident's room had three locked medication storage cupboards, accessed by the staff with a key.

During observation of medication storage on May 6, 2022, at approximately 1:55 p.m., the surveyor observed unlicensed personnel (ULP)-L unlock the top cupboard; however, ULP-L was able to open the second cupboard without a key. ULP-L verified the cupboard was not locked. The second cupboard held unopened punch cards of the following medications:
- valproic acid (treats seizures disorders, mental/mood conditions) 250 mg (milligrams) two

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| 01880 | Continued From page 56<br>cards;<br>- venlafaxine (used to treat depression) 75 mg;<br>- tamsulosin (used to treat enlarged prostate) 0.4 mg; and<br>- Clear Lax (used to treat constipation) 3350 powder.<br><br>On May 6, 2022, at approximately 2:00 p.m., ULP-L stated the medication cupboards should always be locked.<br><br>On May 6, 2022, at approximately 2:02 p.m., licensed practical nurse (LPN)-J indicated medication storage cupboards in the residents' rooms should always be locked.<br><br>The licensee's Storage of Medications policy, effective August 1, 2021, indicated a registered nurse must conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications and whether secured storage is appropriate given the resident's functional and cognitive status, concerns about the potential for drug diversion or other considerations. The policy lacked direction to ensure medication cupboards are locked and secured.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01910 SS=D | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or | 01910 | | |

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| 01910 | Continued From page 57 | 01910 | | |

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 one resident (R5) upon discharge, with records reviewed.

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

The findings include:

R5's record lacked documentation of the

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| 01910 | Continued From page 58<br>disposition of medications to include the following required content:<br>- medication's name;<br>- strength;<br>- prescription number as applicable;<br>- quantity;<br>- to whom the medication was given;<br>- date of disposition; and<br>- names of staff and other individuals involved in the disposition.<br><br>R5 was discharged on December 2, 2021.<br><br>R5's prescriber orders dated November 16, 2021, included one anti-anxiety medication and one anti-depressant.<br><br>R5's Discharge Summary dated December 3, 2021, indicated all medications had been taken to the new facility, including the Ativan.<br><br>On May 6, 2022, at approximately 1:00 p.m., housing director (HD)-D confirmed the licensee had not completed a medication disposition with the required content.<br><br>The licensee's Med (medication) Safe policy dated March 3, 2022, noted upon disposition, the facility must document in the resident's record the disposition including the medication name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and the names of staff and other individuals involved in the disposition.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |

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| 01970 | Continued From page 59 | 01970 | | |
| 01970 SS=D | 144G.72 Subd. 6 Treatment and therapy orders<br><br>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review the licensee failed to ensure clarification of prescriber orders for one of three residents (R3) with records reviewed.<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>R3's last signed prescriber orders dated April 6, 2021, indicated diet order of mechanical soft with thin liquids; however, the unsigned Physician Order Report printed May 3, 2022, included diet order of regular texture and thin liquids with "Special Instructions: On Mildly thick liquids."<br><br>The orders lacked a clear description of the | 01970 | | |

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| 01970 | Continued From page 60<br>treatment for modified diet.<br><br>On May 3, 2022, at approximately 9:15 a.m., R3 was sitting at the bar type U-shaped counter in the kitchenette area, independently eating yogurt.<br><br>R3's Service Plan With Schedule, dated May 3, 2022, indicated R3's current diet was "minced and moist texture mildly thick liquids," and directed, "Provide choices for food item/drink, use a slow rate, ensure items are chewed and swallowed before next bite/drink...[R3] is now on a moist and minced diet and mildly thick liquids."<br><br>R3's Resident Evaluation for [R3], Marywood AL (assisted living)/IL (independent living), dated May 2, 2022, indicated R3's current diet was "minced and moist texture mildly thick liquids," and directed assistance was needed occasionally in opening and applying condiments, diet teaching, reminders to adhere to diet, increase fluids, and assist with food selection. Also included, "Ensure an upright position, oral hygiene/mouth is clean. Report any coughing, SOB [shortness of breath], vomiting, or difficulty with chewing/swallowing, excessive throat clearing...[R3] is now on a moist and minced diet and mildly thick liquids."<br><br>On May 6, 2022, at approximately 12:08 p.m., director of nursing (DON)-C verified the diet orders were not clear and stated she didn't know if staff were providing thin or thickened liquids to R3.<br><br>On May 6, 2022, at approximately 3:11 p.m., unlicensed personnel (ULP)-M stated R3 was given "regular" liquids for meals, and stated "thin, not thickened." ULP-M indicated R3 did well with liquids when sitting up at meals, but sometimes | 01970 | | |

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| 01970 | Continued From page 61<br>coughed when given liquid Tylenol while lying in bed.<br><br>The licensee's Medication & Treatment Orders-Receiving, Implementing, Renewal and Re-ordering policy, effective August 1, 2022, indicated assuring treatment orders were up-to-date and administered in accordance to provider orders, must be dated and signed by the provider, and were current and consistent with the nursing assessment.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) | 01970 | | |
| 02260 SS=C | 144G.90 Subd. 3 Notice of dementia training<br><br>An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered with records reviewed.<br><br>This practice resulted in a level one violation (a | 02260 | | |

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| 02260 | Continued From page 62 | 02260 | | |

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:

The licensee had an Assisted Living with Dementia Care license, effective August 1, 2021, through July 31, 2022.

During the entrance conference on May 2, 2022, at approximately 1:06 p.m., licensed assisted living director (LALD)-A and housing director (HD)-D verified the licensee had a locked dementia care unit on the first floor, and high acuity residents with dementia on the second floor. The surveyor requested a copy of the dementia training disclosure.

The licensee's Dementia Disclosure: Specialized Memory Care Community, undated, noted staff training would include dementia training to all direct care staff and their supervisors, and would include a current explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, effective approaches to use to problem solve when working with a resident's challenging behavioral expressions, how to communicate with residents living with Alzheimer's disease or other dementia subtypes, and other topics as determined necessary based upon the needs of the resident. The disclosure lacked the following required content:
- the frequency of training.

On May 6, 2022, at approximately 11:43 a.m.,

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| 02260 | Continued From page 63<br>HD-D verified the disclosure did not include the frequency of training, as required.<br><br>A policy was requested but not provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 02260 | | |
| 02310 SS=I | 144G.91 Subd. 4 Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for three of three residents (R2, R3 and R4) with bedrails (used interchangeably with siderails), with records reviewed.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was 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>This practice resulted in an immediate correction order related to resident identifiers, R2, R3 and | 02310 | On May 6, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three and scope of widespread. | |

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| 02310 | Continued From page 64<br><br>R4.<br>The findings include:<br>R2<br>R2's diagnoses included Alzheimer's disease and Lewy Body dementia.<br><br>On May 3, 2022, at approximately 9:30 a.m., the surveyor observed R2 in bed on his back, leaning toward the left side. R2's bed was equipped with an upside-down U-shaped device located on the right side of a twin-sized mattress near the head of the bed (HOB). The device was off white metal, affixed to the bed, with two horizontal bars between the U-shaped bars.<br><br>R2's Resident Evaluation dated April 29, 2022, indicated under Assistive Devices, "Use of side rail or grab bar or other device for when in bed" with notes including:<br>- risk vs. [versus] benefits explained, and consent signed on date to meet the FDA's [Food and Drug Administration] dimensional guidance, each designated space in zones 1-3 must not exceed 4 3/4 inches and zone 4 must not exceed 2 3/8 - MET inches (see front for zone pictorial);<br>- potential benefits: aiding in turning and repositioning within the bed, providing a handhold for getting into or out of bed, providing a feeling of comfort and security, reducing the risk of patient [resident] falling out of bed when transferring, providing easy access to bed controls and personal care items; and<br>- frequency indicating "Weekly 1 times."<br>The evaluation lacked the device measurements, compliance with the FDA recommendations and attempted safety interventions or alternatives offered for bedrail usage.<br><br>R2's "Side Rails*" document dated April 29, 2022, noted the following: | 02310 | | |

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| 02310 | Continued From page 65<br>- medical symptoms requiring use of siderails or grab bars "altered balance, has mobility handle only";<br>- reason for siderail or grab bar usage "Assist with transfers";<br>- types of rails to be used "Left";<br>- siderails installed appropriately and are secure "Yes";<br>- frequency of use "Daily";<br>- risk and benefits were explained to client [resident], family, including the risk of significant injury if a fall occurs "Yes";<br>- date the risk and benefits were explained "03/02/22";<br>- full name of person(s) to whom the risk and benefits were explained to (left blank); and<br>- informed consent signed and side rail brochure given to client or family, POA (Power of Attorney) "Yes".<br>The document lacked the device measurements, compliance with the FDA recommendations and attempted safety interventions or alternatives offered for bedrail usage.<br><br>R2's Bed Rail Education and Consent Form dated June 10, 2021, indicated the potential benefits and potential risks of bedrails and was signed by R2's representative. The form lacked the device measurements, compliance with the FDA recommendations and attempted safety interventions or alternatives offered for bedrail usage.<br><br>On May 5, 2022, at approximately 8:20 a.m., the surveyor observed director of nursing (DON)-C measure R2's bedrail. The bedrail measured 7 5/8 inches horizontally and 3 5/8 inches within the rail (zone 1); 9 1/4 inches between the end of the rail and the side edge of the headboard (zone 6); and 2 inches between the rail and the mattress | 02310 | | |

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| 02310 | Continued From page 66<br>(zone 3).<br><br>R2's Service Plan with Schedule effective April 29, 2022, noted services including assistance with activities of daily living (ADL), medication management and diabetic management. In addition, the service plan indicated "Use of side rail or grab bar or other device for when in bed" with notes including:<br>- risk vs. benefits explained, and consent signed on date to meet the FDA's dimensional guidance, each designated space in zones 1-3 must not exceed 4 3/4 inches and zone 4 must not exceed 2 3/8 - MET inches (see front for zone pictorial);<br>- potential benefits: aiding in turning and repositioning within the bed, providing a handhold for getting into or out of bed, providing a feeling of comfort and security, reducing the risk of patient [resident] falling out of bed when transferring, providing easy access to bed controls and personal care items; and<br>- frequency indicating "Weekly 1 times."<br>The service plan lacked the device measurements, compliance with the FDA recommendations and attempted safety interventions or alternatives offered for bedrail usage.<br><br>R3<br>R3's diagnoses included mild cognitive impairment, weakness, malaise, and difficulty in walking.<br><br>On May 3, 2022, at approximately 3:27 p.m., the surveyor observed R3 resting in bed, with the HOB slightly elevated. R3's bed was equipped with bilateral upside-down U-shaped devices on a twin-sized mattress near the HOB. The devices were off white metal, affixed to the bed, with two horizontal bars between the U-shaped bars. | 02310 | | |

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| 02310 | Continued From page 67<br><br>R3's Resident Evaluation dated May 2, 2022, indicated under Assistive Devices, "Use of side rail or grab bar or other device for when in bed," with frequency including "As needed." Further, the evaluation noted R3's emergency contact was her daughter, also identified as her POA.<br>The evaluation lacked the device measurements, compliance with the FDA recommendations and attempted safety interventions or alternatives offered for bedrail usage.<br><br>R3's Bed Rail Education and Consent Form dated May 3, 2022, indicated the potential benefits and potential risks of bedrails, included what appeared to be "I L." This was later identified by DON-C to be an electronic signature by R3's POA.<br>The form lacked the device measurements, compliance with the FDA recommendations and attempted safety interventions or alternatives offered for bedrail usage.<br><br>On May 5, 2022, at approximately 8:27 a.m., the surveyor observed DON-C measure R3's bedrails. The bedrails measured 7 1/2 inches horizontally and 3 5/8 inches on the top opening and 4 inches on the bottom opening within the rail (zone 1); 18 inches between the end of the rail and the side edge of the headboard on the left side and 9 inches on the right side (zone 6); and 1 inch between the rail and the mattress (zone 3).<br><br>R3's Service Plan with Schedule effective May 3, 2022, noted services including assistance with ADLs, medication management, transfer assistance, and extensive meal assistance. In addition, the service plan indicated R3 had siderails she used to assist with bed mobility.<br>The service plan lacked the device | 02310 | | |

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measurements, compliance with the FDA recommendations and attempted safety interventions or alternatives offered for bedrail usage.

R4
R4's diagnoses included anemia in chronic kidney disease, abnormalities of gait and mobility and weakness.

On May 3, 2022, at approximately 11:00 a.m., the surveyor observed R4 sitting in the recliner in his room. R4's bed was equipped with bilateral upside-down U-shaped devices on a twin-sized mattress near the HOB. The devices were off white metal, affixed to the bed, with two horizontal bars between the U-shaped bars.

R4's Bed Rail Education and Consent Form dated February 7, 2022, indicated the potential benefits and potential risks of bedrails, signed by the resident's POA. The form lacked the device measurements, compliance with the FDA recommendations and attempted safety interventions or alternatives offered for bedrail usage.

R4's Service Plan with Schedule effective March 9, 2022, noted services including occasional assistance with dressing, assistance with bathing, transfer assistance, diabetic management and medication management. The service plan lacked the device measurements, compliance with the FDA recommendations and attempted safety interventions or alternatives offered for bedrail usage.

R4's Resident Evaluation dated March 9, 2022, indicated "Use of side rail or grab bar or other device for when in bed," with frequency including

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"As needed." The evaluation lacked the device measurements, compliance with the FDA recommendations and attempted safety interventions or alternatives offered for bedrail usage.

R4's Side Rail/Grab/Mobility Assist Bar assessment dated May 2, 2022, indicated:
- medical symptoms requiring use of siderails or grab bars "Positioning";
- reason for siderail or grab bar usage "Assist with transfers Bed mobility, assisting to turn side to side";
- types of rails to be used "Grab bar secured to bed";
- measurements of devices "Rail or other mobility device does not meet regulatory FDA recommendations";
- side rails are secure "Yes";
- frequency of use "As needed";
- risk and benefits were explained to client [resident], family, including the risk of significant injury if entrapment occurs "Yes";
- if applicable, resident or POA understand increased safety risk with rail or device not meeting FDA recommendations (left blank);
- date the risk and benefits were explained "02/07/22";
- full name of person(s) to whom the risk and benefits were explained to (left blank); and
- informed consent signed and side rail brochure given to client [resident] or family, POA - "Yes."
The document lacked the device measurements, compliance with the FDA recommendations and attempted safety interventions or alternatives offered for bedrail usage.

On May 5, 2022, at approximately 8:33 a.m., the surveyor observed DON-C measure R3's bedrails. The right bedrail measured 7 1/2 inches

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horizontally and 4 inches vertically within the rail (zone 1); 7 1/2 inches between the end of the rail and the side edge of the headboard on the left side (zone 6); and 1 inch between the rail and the mattress (zone 3). The left side measured 7 3/4 inches horizontally, 3 3/4 inches vertically on the top opening and 4 inches on the lower opening in zone 1, 16 3/4 inches on zone 6; and 1/2 inch at zone 3.

On May 4, 2022, at approximately 2:35 p.m., licensed assisted living director (LALD)-A and DON-C stated they had a new form that was implemented on Saturday (April 30, 2022); however, stated, although it was in process, none of the siderail assessments had been completed to date. LALD-A stated the current siderails were all the same and were not compliant with the FDA guidelines. DON-C stated they identified this issue and "did assessments" approximately a week and a half ago which were put on a spreadsheet to include the measurements, and at that time those residents found not to be using the siderails had them removed. LALD-A stated they were currently looking for options for bedrails that would be compatible with the current bed and within the FDA guidelines. In addition, they stated they had spoken to the families about the situation, and some families chose to keep them. When asked what interventions had been implemented to keep the residents safe, DON-A stated they round every two hours on residents and made sure the residents had access to their pendants and pay close attention to the residents who were restless in bed. LALD-A stated they had started the process in the last couple weeks.

On May 4, 2022, at approximately 3:00 p.m., the surveyor requested a copy of the spreadsheet and all documentation related to the use of

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siderails, assessments, and risk versus benefits. At 3:53 p.m., the surveyor a left a message for DON-C on her voicemail inquiring about the status of the requested information. At 4:05 p.m., the surveyor left a message for LALD-A with a staff member that stated she was helping LALD-A out by answering her phone calls, inquiring about the status of the requested documentation. At 4:29 p.m., the surveyor made a call to housing director (HD)-D inquiring about the status of the requested documentation. At that time, HD-D stated LALD-A was en route with the documentation.

On May 4, 2022, at approximately 4:31 p.m., LALD-A stated the spreadsheet was "messy and not helpful." At approximately 4:47 p.m., LALD-A stated they had assessed all of the residents, and again stated the devices were not FDA compliant, and some were taken off, but there was no formal assessment documented. In addition, DON-C stated:
- there was a lot of internal conversation to whether the devices were truly siderails and if the assessment and measurement had to be completed;
- the zones were measured but none were documented;
- the spread sheet was just a tracking tool;
- all of the siderails were the same measurement;
- no comprehensive individualized assessment was completed for any of the residents with side rails;
- interventions included:
    - discussion of the list of residents with siderails with the charge nurse to determine which siderails could be removed, adding the siderails were removed on May 2, 2022, after the survey team entered;
- those residents that continued to have siderails

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were not "movers" and didn't go to the open space.
DON-C verified all of the above internal conversation was verbal and none of it was documented and stated she was not sure if the charge nurse obtained family or resident approval before removing the bedrails.

On May 5, 2022, at approximately 8:05 a.m., DON-C stated 30-minute checks had been implemented for residents with bedrails while in bed, effective last evening.

On May 5, 2022, at approximately 8:45 a.m., the surveyor observed each room on the second floor to compare the bedrails to the undated Marywood Bed Rail Audit provided by DON-C on May 4, 2022. The audit form noted "All bedrails measure 3.5 x 7.5 zone 1." The surveyors observed five rooms that were identified as having bedrails, but none were present and two rooms that the licensee identified as having bedrails removed but had bilateral bedrails on the beds. In addition, the surveyor observed three rooms to have bedrails that the licensee had not identified on the audit list and two beds that were identified to have bedrails were a different model than the ones the surveyors observed DON-C to measure.

On May 5, 2022, at approximately 9:18 a.m., unlicensed personnel (ULP)-E stated they did hourly safety checks on everyone, and she was not aware of any changes implemented to do 30-minute checks on anyone.

On May 5, 2022, at approximately 9:26 a.m., HD-D confirmed the licensee implemented 30-minute safety checks on residents with bedrails when the residents are in bed. HD-D stated it was communicated to staff through

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 31068 | A. BUILDING: _____ B. WING _____ | 05/06/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARYWOOD | 915 KENWOOD AVENUE DULUTH, MN 55811 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 73 | 02310 | | |

face-to-face conversation and nursing was instructed to check that it was done on the flowsheet. However, on May 5, 2022, at this time the surveyor and HD-D observed the flowsheets for the "Driftwood neighborhood" unit, and HD-D confirmed staff had not documented the 30-minute safety checks.

On May 5, 2022, at approximately 9:52 a.m., the surveyor observed each room on the first floor to compare the bedrails to the undated Marywood Bed Rail Audit provided by DON-C on May 4, 2022. The audit form noted "All bedrails measure 3.5 x 7.5 zone 1." The surveyor observed two rooms to have bedrails, that had not been identified on the audit list, both of which were a different model than the ones the surveyor observed DON-C to measure. The surveyor also observed two rooms identified by the licensee as having had bedrails removed but had bilateral bedrails on the beds.

On May 5, 2022, at approximately 10:26 a.m., DON-C stated a sweep of the rooms done "wasn't thorough" and verified measurements of the devices was not done and/or documented. DON-C stated "We knew it was a problem, should we have been quicker to do something more? Yes." In addition, DON-C stated no interventions were put in place immediately and they have work to do. DON-C stated there had not been an entrapment at the facility. In addition, DON-C stated she thought all of the bedrails utilized were the same and had the same measurements.

The licensee's Side Rail Policy dated August 1, 2021, noted the registered nurse (RN) would assess and evaluate the residents' needs to determine if the resident could safely utilize the

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| | 31068 | A. BUILDING: _____ B. WING _____ | 05/06/2022 |

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|---|---|---|---|---|
| 02310 | Continued From page 74 | 02310 | | |

siderail/equipment and determine whether the siderail/equipment met the FDA standard for siderails. In addition, the policy noted the RN would educate the resident's representative / family regarding siderail safety and risks including potential death due to falls, entrapment and asphyxiation. If the RN determined the resident was not able to use the siderail or the resident's siderail did not meet the FDA or most current safety guidelines, the RN would recommend the siderail should be removed and would document this recommendation. If the RN determined the siderails were not a safe device for the resident, the RN would provide options and alternatives for reducing fall or positioning self to the resident, the resident's representative and/or family. If the RN determined the siderail was unsafe, and the resident's representative or family did not want it removed, the RN would document the findings, conversations with the resident / family, any education provided, as well as alternatives offered, and family's refusal to comply with safety. Continued use of siderails would be completed every 90 days to determine if the siderail was still needed to enhance their safety / bed mobility.

The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle.

The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When

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|---|---|---|---|
| | 31068 | A. BUILDING: _____ B. WING _____ | 05/06/2022 |

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|---|---|---|---|---|
| 02310 | Continued From page 75<br><br>bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe".<br><br>TIME PERIOD FOR CORRECTION: Immediate<br><br>On May 6, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three and scope of widespread. | 02310 | | |
| 03070 SS=E | 144.6502, Subd. 6 Form Requirements<br><br>Subd. 6.Form requirements.<br><br>(b) Facilities must make the notification and consent form available to the residents and inform residents of their option to conduct electronic monitoring of their rooms or private living unit.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to obtain consent for electronic monitoring for two of three residents (R6 and R2) who had an electronic monitoring device in place.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 03070 | | |

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|---|---|---|---|---|
| 03070 | Continued From page 76 | 03070 | | |

safety but had the potential to have harmed a resident's health or safety), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R6 and R2's records lacked a written consent to place an electronic monitoring device in the residents' rooms.

R2
R2's diagnoses included Alzheimer's disease and Lewy Body dementia.

R2's Service Plan with Schedule effective April 29, 2022, noted services including assistance with activities of daily living (ADL), medication management and diabetic management.

R6
R6's diagnoses included Alzheimer's disease.

R6's Service Plan With Schedule dated May 3, 2022, noted services including assistance with bathing and medication management.

On May 4, 2022, at approximately 10:40 a.m., the surveyor observed a small monitoring device on the counter next to the kitchenette area in the Driftwood neighborhood on the locked dementia unit, facing out toward the common area of the neighborhood. Next to the counter was a bar type U-shaped counter for residents to sit at for meals. A visitor was standing at the U-shaped counter, approximately 10 feet from where the monitor was placed. The monitor showed R6 in his bed,

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| | 31068 | A. BUILDING: _____ B. WING _____ | 05/06/2022 |

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| MARYWOOD | 915 KENWOOD AVENUE DULUTH, MN 55811 |

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| 03070 | Continued From page 77<br><br>apparently asleep. At that time, unlicensed personnel (ULP)-K stated the monitor was used to observe 3 residents on the unit since they were at risk for falls. ULP-K stated the monitor should be on their person but was on the counter at the time for charging. In addition, ULP-K agreed it was a privacy concern as there was a visitor in the area, removed the device from the counter and placed it in her pocket.<br><br>On May 5, 2022, at approximately 9:15 a.m., the surveyor observed the monitoring device was again on the counter next to the kitchenette area in the Driftwood neighborhood, facing out toward the common area of the neighborhood, and displayed R6 in his bed. ULP-E stated it was normal practice for staff to leave the monitor on the counter, and staff had not been instructed otherwise. ULP-E stated the monitor remained on for R6 at all times, and for two other residents (R2 and R7) only at night or when in bed.<br><br>On May 5, 2022, at approximately 9:30 a.m., housing director (HD)-D verified the monitor was on the counter facing out but stated typically it was placed inside the counter in the kitchen where it would not be seen by others. In addition, HD-D stated it would be a privacy concern if it was able to be observed by visitors. HD-D stated they speak with family to get consent and document this.<br><br>On May 5, 2022, at approximately 9:30 a.m., housing director (HD)-D verified the monitor was on the counter facing out, but stated typically it was placed inside the counter in the kitchen where it would not be seen by others. In addition, HD-D stated it was a privacy concern if able to be observed by visitors. HD-D stated they speak with family to get consent and documented it. | 03070 | | |

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|---|---|---|---|---|
| 03070 | Continued From page 78<br><br>On May 6, 2022, at approximately 12:55 p.m., HD-D verified although there was a consent in place for another resident, R2 and R6's records lacked a consent for the electronic monitoring. In addition, HD-D stated she was in the process of getting consent for all residents using the form provided by the Minnesota Department of Health.<br><br>The licensee's Monitoring Devices in Resident Rooms - MN policy dated February 12, 2020, noted prior to conducting electronic monitoring, a resident/resident representative must consent in writing on the form developed by the MN Department of Health.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 03070 | | |

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *05/03/22*
Time: 12:15:00
Report: 1016221086

# Food and Beverage Establishment Inspection Report



**Location:**
Marywood - CLIFF ROCKS
915 Kenwood Avenue
Duluth, MN55811
St. Louis County, 69

**Establishment Info:**
ID #: 0039371
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 2185228904
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.

**6-300 Physical Facility Numbers and Capacities**

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

SEVERAL HAND WASHING SINKS DID NOT HAVE A REMINDER SIGN. INSPECTOR PROVIDED SIGNS AND STAFF POSTED THEM DURING INSPECTION.

*Corrected on Site*

**Surface and Equipment Sanitizers**

Hot Water: = at 176 Degrees Fahrenheit
Location: DISH WAHER
Violation Issued: No

Sink/Surface Cleaner: = 700 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Hot Holding
Temperature: 160 Degrees Fahrenheit - Location: BEEF
Violation Issued: No

Process/Item: Hot Holding
Temperature: 163 Degrees Fahrenheit - Location: SOUP
Violation Issued: No

Type: Full
Date: *05/03/22*
Time: 12:15:00
Report: 1016221086
Marywood - CLIFF ROCKS

# Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

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

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

COMMENTS:

DISCUSSED RAPID COOLING STRATEGIES WITH STAFF.

MAJORITY OF FOOD IS PREPARED AT WEST WOOD MAIN KITCHEN.

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

**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 1016221086 of 05/03/22.

Certified Food Protection Manager GINA M. CARDINAL

Certification Number: FM100634 Expires: 09/17/22

Signed: _____
GINA M. CARDINAL

Signed: _____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us

Report #: 1016221086

# Food Establishment Inspection Report

DEPARTMENT OF HEALTH

**Minnesota Department of Health**
**11 East Superior St.**
**Duluth**

| | | | |
|---|---|---|---|
| **No. of RF/PHI Categories Out** | 1 | **Date** | 05/03/22 |
| **No. of Repeat RF/PHI Categories Out** | 0 | **Time In** | 12:15:00 |
| **Legal Authority MN Rules Chapter 4626** | | **Time Out** | |

| Marywood CLIFF ROCKS | **Address** 915 Kenwood Avenue | **City/State** Duluth, MN | **Zip Code** 55811 | **Telephone** 2185228904 |
|---|---|---|---|---|
| **License/Permit #** 0039371 | **Permit Holder** | **Purpose of Inspection** Full | **Est Type** | **Risk Category** |

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

| | Compliance Status | | COS | R |
|---|---|---|---|---|
| | **Supervision** | | | |
| 1 | IN OUT | PIC knowledgeable; duties & oversight | | |
| 2 | IN OUT N/A | Certified food protection manager, duties | | |
| | **Employee Health** | | | |
| 3 | IN OUT | Mgmt/Staff;knowledge,responsibilities&reporting | | |
| 4 | IN OUT | Proper use of reporting, restriction & exclusion | | |
| 5 | IN OUT | Procedures for responding to vomiting & diarrheal events | | |
| | **Good Hygenic Practices** | | | |
| 6 | IN OUT N/O | Proper eating, tasting, drinking, or tobacco use | | |
| 7 | IN OUT N/O | No discharge from eyes, nose, & mouth | | |
| | **Preventing Contamination by Hands** | | | |
| 8 | IN OUT N/O | Hands clean & properly washed | | |
| 9 | IN OUT N/A N/O | No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed | | |
| 10 | IN OUT | Adequate handwashing sinks supplied/accessible | X | |
| | **Approved Source** | | | |
| 11 | IN OUT | Food obtained from approved source | | |
| 12 | IN OUT N/A N/O | Food received at proper temperature | | |
| 13 | IN OUT | Food in good condition, safe, & unadulterated | | |
| 14 | IN OUT N/A N/O | Required records available; shellstock tags, parasite destruction | | |
| | **Protection from Contamination** | | | |
| 15 | IN OUT N/A N/O | Food separated and protected | | |
| 16 | IN OUT N/A | Food contact surfaces: cleaned & sanitized | | |
| 17 | IN OUT | Proper disposition of returned, previously served, reconditioned, & unsafe food | | |

| | Compliance Status | | COS | R |
|---|---|---|---|---|
| | **Time/Temperature Control for Safety** | | | |
| 18 | IN OUT N/A N/O | Proper cooking time & temperature | | |
| 19 | IN OUT N/A N/O | Proper reheating procedures for hot holding | | |
| 20 | IN OUT N/A N/O | Proper cooling time & temperature | | |
| 21 | IN OUT N/A N/O | Proper hot holding temperatures | | |
| 22 | IN OUT N/A | Proper cold holding temperatures | | |
| 23 | IN OUT N/A N/O | Proper date marking & disposition | | |
| 24 | IN OUT N/A N/O | Time as a public health control: procedures & records | | |
| | **Consumer Advisory** | | | |
| 25 | IN OUT N/A | Consumer advisory provided for raw/undercooked food | | |
| | **Highly Susceptible Populations** | | | |
| 26 | IN OUT N/A | Pasteurized foods used; prohibited foods not offered | | |
| | **Food and Color Additives and Toxic Substances** | | | |
| 27 | IN OUT N/A | Food additives: approved & properly used | | |
| 28 | IN OUT | Toxic substances properly identified, stored, & used | | |
| | **Conformance with Approved Procedures** | | | |
| 29 | IN OUT N/A | Compliance with variance/specialized process/HACCP | | |

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

## GOOD RETAIL PRACTICES

**Good Retail Practices** are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

| | | | COS | R |
|---|---|---|---|---|
| | | **Safe Food and Water** | | |
| 30 | IN OUT N/A | Pasteurized eggs used where required | | |
| 31 | | Water & ice obtained from an approved source | | |
| 32 | IN OUT N/A | Variance obtained for specialized processing methods | | |
| | | **Food Temperature Control** | | |
| 33 | | Proper cooling methods used; adequate equipment for temperature control | | |
| 34 | IN OUT N/A N/O | Plant food properly cooked for hot holding | | |
| 35 | IN OUT N/A N/O | Approved thawing methods used | | |
| 36 | | Thermometers provided & accurate | | |
| | | **Food Identification** | | |
| 37 | | Food properly labled; original container | | |
| | | **Prevention of Food Contamination** | | |
| 38 | | Insects, rodents, & animals not present | | |
| 39 | | Contamination prevented during food prep, storage & display | | |
| 40 | | Personal cleanliness | | |
| 41 | | Wiping cloths: properly used & stored | | |
| 42 | | Washing fruits & vegetables | | |

| | | | COS | R |
|---|---|---|---|---|
| | | **Proper Use of Utensils** | | |
| 43 | | In-use utensils: properly stored | | |
| 44 | | Utensils, equipment & linens: properly stored, dried, & handled | | |
| 45 | | Single-use/single service articles: properly stored & used | | |
| 46 | | Gloves used properly | | |
| | | **Utensil Equipment and Vending** | | |
| 47 | | Food & non-food contact surfaces cleanable, properly designed, constructed, & used | | |
| 48 | | Warewashing facilities: installed, maintained, & used; test strips | | |
| 49 | | Non-food contact surfaces clean | | |
| | | **Physical Facilities** | | |
| 50 | | Hot & cold water available; adequate pressure | | |
| 51 | | Plumbing installed; proper backflow devices | | |
| 52 | | Sewage & waste water properly disposed | | |
| 53 | | Toilet facilities: properly constructed, supplied, & cleaned | | |
| 54 | | Garbage & refuse properly disposed; facilities maintained | | |
| 55 | | Physical facilities installed, maintained, & clean | | |
| 56 | | Adequate ventilation & lighting; designated areas used | | |
| 57 | | Compliance with MCIAA | | |
| 58 | | Compliance with licensing & plan review | | |

**Food Recalls:**

**Person in Charge (Signature)** **Date:** 05/05/22

Inspector (Signature)