



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 11, 2023

Licensee
The Meadows
1761 Eagle View Circle
Albert Lea, MN 56007

RE: Project Number(s) SL32452015

Dear Licensee:

On September 20, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on June 23, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 23, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on June 23, 2023, found not corrected at the time of the September 20, 2023, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on September 20, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

Also, at the time of this follow-up survey completed on September 20, 2023, we identified the following violation(s):

0690-Resident Record-144g.43 Subdivision 1
1890-Prescription Drugs-144g.71 Subd. 20

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to

comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/20/2023
NAME OF PROVIDER OR SUPPLIER THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL32452015-1 On September 18, 2023, through September 20, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on June 23, 2023. At the time of the survey, there were 30 residents: 29 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of four residents (R10). 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	{0 630}			

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{0 630}	Continued From page 2 of staff are involved, or the situation has occurred only occasionally). The findings include: R10 was admitted on May 2, 2022, and had diagnoses to include dementia and chronic kidney disease. R10's service plan was requested but clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated it could not be located. R10's record did not include an IAAP which assessed the resident's susceptibility to abuse by another individual, including other vulnerable adults; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults. On September 19, 2023, at 11:22 a.m., CNS/LALD-A stated R10 had a written IAAP that was completed upon admission, but it could not be located. CNS/LALD-A provided an IAPP for R10 dated September 18, 2023, which was completed after the survey started. The licensee's Individual Abuse Prevention Plan policy dated June 30, 2023, indicated an individual abuse prevention plan would be developed for each resident as part of the initial service plan. It further indicated the IAAP plan would be reviewed at least annually. No further information was provided.	{0 630}			

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{0 680}	Continued From page 3	{0 680}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post an emergency disaster plan prominently. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	{0 680}			

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{0 680}	Continued From page 4 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 prominently post the emergency disaster plan. On September 18, 2023, at 10:00 a.m. during the entrance conference, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated a sign had been created and posted in the facility for the emergency disaster plan. On September 18, 2023, at 1:10 p.m. observation of the facility identified no posted facility emergency disaster plan. On September 18, 2023, at 1:28 p.m. CNS/LALD-A stated the emergency disaster plan sign had been posted by the receptionist near the front entrance. However, the sign had been taken down at the request of upper management since it did not match the decor. No further information was provided.	{0 680}			
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.	0 690			

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0 690	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in one of one resident record (R10) were authenticated by the name and title of the person making the entry. 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: R10's Medication Administration Record (MAR) dated August 2023, and September 1, 2023, through September 30, 2023, was reviewed and had a page for staff to write in their name, title, and initials. Clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A had initials on R10's MAR dated August 1, 8, 15, 22, 29, 2023, and September 5, 11, 12, 2023. CNS/LALD-A was not identified by name, initials, or title on either of R10's August or September's MAR. On September 19, 2023, at 9:11 a.m. CNS/LALD-A stated each employee needs to have their name with title and initials on each resident's MAR, this can be done electronically or by manually writing it in. CNS/LALD-A stated staff initials should be authenticated with name and title.	0 690			

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0 690	Continued From page 6 The licensee's undated, Content of Client Records policy indicated entries would be dated and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
{0 800} SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	{0 810}			

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{0 810}	Continued From page 7 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}			
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne	{01370}			

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{01370}	Continued From page 8 pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of three unlicensed personnel (ULP-L).	{01370}			

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{01370}	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-L began providing direct care services for the licensee on October 19, 2022, under the assisted living with dementia care licensure. ULP-L's employee record lacked evidence the following education and/or competencies had been completed prior to providing direct cares: - training on the prevention of falls for providers working with the elderly or individuals at risk of falls. On September 20, 2023, at 12:10 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated ULP-L's record did not include the above required training. The licensee's Unlicensed Personnel - Training and Competency Evaluation policy revised May 2023, indicated: 3. Training content for Unlicensed Personnel and competency Evaluation. Following are the required training topics for unlicensed personnel, with notation regarding the type of competency evaluation that is required. f. training on the prevention of falls for providers working with the elderly or individuals at risk of falls (written or oral test required).	{01370}			

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{01370}	Continued From page 10 No further information was provided.	{01370}			
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for two of four residents (R6, R9). This practice resulted in a level two violation (a	{01620}			

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{01620}	Continued From page 11 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: R6 R6's Service Plan dated July 30, 2021, indicated R6 received services including medication administration. R6's last assessment was requested and received on September 20, 2023. The provided assessment was dated April 17, 2023; 156 days had passed since the last assessment. On September 20, 2023, at 9:50 a.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R6's assessment had not been completed within 90 days as required. R9 R9's Service Plan dated February 1, 2022, indicated R9 received services including medication administration. R9's most recent assessment was requested and received on September 20, 2023. The assessment was dated April 17, 2023; 156 days had passed since the last assessment. On September 20, 2023, at 11:24 a.m. CNS/LALD-A stated R9's assessment had not been completed within 90 days as required.	{01620}			

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{01620}	Continued From page 12 The licensee's Monitoring of Clients and Their Services policy revised September 24, 2022, noted the registered nurse (RN) would monitor and reassess the resident no more than 90 days from the date of the last visit. No further information was provided.	{01620}			
{01650} SS=C	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	{01650}			

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{01650}	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the correct required content for six of six residents (R2, R3, R5, R6, R9, R13). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 had a diagnosis of dementia. R2's Service Plan dated January 19, 2023, indicated R2 received assistance with medication administration, weekly medication set-up, laundry, and housekeeping. The service plan included a RN assessment would be conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. R3 R3 had a diagnosis of dementia. R3's Service Plan dated May 19, 2022, indicated R3 received services with medication administration and weekly bathing. The service plan included a RN assessment would be	{01650}			

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{01650}	Continued From page 14 conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. R5 R5 had diagnoses including diabetes. R5's Service Plan dated July 31, 2021, indicated R5 received services with medication administration, blood sugar monitoring, and catheter care. The service plan included a RN assessment would be conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. R6 R6 had diagnoses including anxiety, gastroesophageal reflux disease (GERD-heartburn), and glaucoma (is a group of eye conditions that damage the optic nerve). R6's Service Plan dated July 20, 2021, indicated R6 received services with medication administration. The service plan included a RN assessment would be conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. R9 R9 had a diagnosis congestive heart failure (when the heart muscle doesn't pump blood as well as it should) and hypertension (high blood pressure).	{01650}			

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{01650}	Continued From page 15 R9's Service Plan dated February 1, 2022, indicated R9 received services with medication administration. The service plan included a RN assessment would be conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. R13 R13 had a diagnosis of diabetes. R13's service plan dated August 31, 2023, indicated R13 received assistance with medication administration, blood glucose checks, showers, meals, laundry, and housekeeping. The service plan included a RN assessment would be conducted within five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. On September 19, 2023, at 1:11 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the above required content was incorrect in the service plan, and reflective of previous home care statutes. CNS/LALD-A also said the same service plan format was utilized for all residents. The licensee's Development and Revision of the Service Plan policy dated reviewed June 30, 2023, noted all services would be provided in accordance with a suitable and up-to-date, written service plan, based on the individual resident's needs and preferences. No further information was provided.	{01650}			

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{01710}	Continued From page 16	{01710}			
{01710} SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an annual face-to-face medication management reassessment to include all required content for two of four residents (R9, R6). 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 September 18, 2023, at 10:00 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided medication management services to the residents at the facility. R9	{01710}			

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{01710}	Continued From page 17 R9 had a diagnosis congestive heart failure (when the heart muscle doesn't pump blood as well as it should) and hypertension (high blood pressure). R9's Service Plan dated February 1, 2022, indicated R9 received medication administration. R9's record included an undated, Individualized Medication Management Plan signed by a RN no longer employed by the licensee. Another Individualized Medication Management Assessment/Plan for R9 was provided to the surveyor; however, the form was signed and dated September 18, 2023, after the survey entrance. R9's record did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. R6 R6 had diagnoses including anxiety, gastroesophageal reflux disease (GERD-heartburn), and glaucoma (is a group of eye conditions that damage the optic nerve). R6's Service Plan dated July 20, 2021, indicated R6 received medication administration. R6's record included an Assessment of Need for Medication Management Services dated November 15, 2020. Another Individualized Medication Management Assessment/Plan for R6 was provided to the surveyor; however, the form	{01710}			

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{01710}	Continued From page 18 was signed and dated September 18, 2023, after the survey entrance. R9's record did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. On September 20, 2023, at 11:28 a.m. CNS/LALD-A stated R9 and R6's medication management assessment/plan had not been reassessed by the RN annually. CNS/LALD-A stated the RN who had signed R9's medication management plan had not been employed by the licensee since April 2022, greater than one year ago. The licensee's Individualized Medication, Treatment & Therapy Management Plans policy revised June 20, 2023, indicated: Medication, treatment, and therapy management plans will be current and updated when there are changes. No further information was provided.	{01710}			
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (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;	{01750}			

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{01750}	Continued From page 19 (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure insulin via a prefilled insulin pen was administered according to manufacturer instructions by one of one unlicensed personnel (ULP-K). 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: R5's diagnoses included insulin dependent diabetes mellitus. R5's Service Plan dated July 31, 2021, indicated R5 received assistance with medication administration. R5's prescriber orders dated October 12, 2022, included Humalog KwikPen (an injectable medication for diabetes) inject 8 units three times daily before meals subcutaneously (under the skin) plus sliding scale order (if necessary, per blood sugar reading). R5's sliding scale order indicated if blood glucose less than 149, give 0 units; 150-190, give 2 units; 191-230, give 4 units;	{01750}			

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{01750}	Continued From page 20 231-270, give 6 units; 271-310, give 8 units; 311-350, give 10 units; 351-400, give 12 units. On September 18, 2023, at 11:41 a.m. the surveyor observed ULP-K obtain R5's blood sugar which measured 227 mg/dL and ULP-K stated R5 would require four additional units of insulin according to physician orders. ULP-K obtained R5's Humalog KwikPen, removed the cap, then attached a needle to the port of the pen. ULP-K dialed the pen to the prescribed 12 units without priming the pen first; ULP-K stated this was per R5's request. ULP-K did not cleanse the pen port with alcohol prior to attaching the needle to the pen. When interviewed immediately following the observation, ULP-K stated he had not been trained to cleanse the insulin port with alcohol prior to attaching the needle. On September 20, 2023, 10:07 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated expectation with insulin administration via an insulin pen is staff would cleanse the pen port with alcohol prior to attaching a new needle and then prime the pen with two units prior to dialing up the dose. CNS/LALD-A further stated R5 was not the resident who didn't want her insulin pen primed first; this was another resident who had a physician order to omit that step. The licensee's Insulin Administration Policy for Assisted Living reviewed June 30, 2023, indicated: 6. Wipe hub of insulin with alcohol swab. 7. Attach needle in a twist method. 8. Dial 2 units to waste (allows air to be removed from needle tip). The manufacturer package inserts for the	{01750}			

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{01750}	Continued From page 21 Humalog KwikPen revised July 2023, indicated when preparing your pen: Step 1: Pull the pen cap straight off. Do not remove the pen label. Wipe the rubber seal with an alcohol swab. Step 2: Check the liquid in the pen. Humalog should look clear and colorless. Do not use if it is cloudy, colored, or has particles or clumps in it. Step 3: Select a new needle. Pull off the paper tab from the outer needle shield. Step 4: Push the capped needle straight onto the pen and twist the needle on until it is tight. Step 5: Pull off the outer needle shield. Do not throw it away. Pull off the inner needle shield and throw it away. Prime before each injection. Priming you pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. No further information was provided.	{01750}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	{01760}			

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{01760}	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of three residents (R6). 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: R6's Service Plan dated July 30, 2021, indicated R6 received services including medication administration. R6's physician orders dated September 15, 2023, included antacid suspension, give 30 milliliters (ml) by mouth three times a day for acid reflux disease (heartburn) and diclofenac sodium 1% gel (used to relieve pain and swelling from various mild to moderate painful conditions), apply four grams topically four times a day for back/joint/right knee pain. On September 18, 2023, at 11:21 a.m., ULP-K was observed administering medication to R6 including antacid suspension and diclofenac sodium 1% gel. When measuring the antacid suspension, ULP-K poured 15 ml into a plastic medication cup. ULP-K stated the full 30 ml prescribed dose bothered R6's stomach so they	{01760}			

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{01760}	Continued From page 23 only administered half of the dose per R6's request. When preparing R6's diclofenac sodium 1% gel, ULP-K donned gloves and applied approximately a dime size amount of the gel onto a fingertip on his right hand then applied the gel to R6's lower back. Immediately following the observation, the surveyor asked ULP-K how he determined the correct amount of gel to administer. ULP-K stated being told by the nurse to administer approximately a "pea" size for the amount. ULP-K further stated being unaware of a way to measure the gel for administration. Review of R6's September 2023, Medication Administration Record (MAR) indicated the resident was receiving the full 30 ml antacid suspension dose three times a day as prescribed. R6's record did not include evidence to support receiving only half the dose. On September 20, 2023, at 10:07 a.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated prescribed gels and ointments should be measured with the plastic measurement care provided with the medication. A subsequent interview at 11:23 a.m., CNS/LALD-A stated if only half the dosage of a medication was being administered, there would be a note in the MAR to reflect as such. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy revised June 30, 2023, indicated: 2. Medications, treatment and therapy always need to be administered according to the "6 Rights" a. Right person b. Right medication, treatment, or therapy c. Right time d. Right route (by mouth, eye drops, to the	{01760}			

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{01760}	Continued From page 24 skin, etc.) e. Right dose (how many milligrams, drops, etc.) f. Right chart/record to document that the medication, treatment, and therapy was taken. No further information was provided.	{01760}			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications had an opened date for one of one resident (R5) with insulin and failed to ensure accurate labeling for one of one resident (R6) with a prescription gel. 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:	01890			

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01890	Continued From page 25 R5 R5's diagnoses included insulin dependent diabetes mellitus. R5's Service Plan dated July 31, 2021, indicated R5 received assistance with medication administration. R5's physician orders dated October 12, 2022, included Humalog KwikPen (an injectable medication for diabetes) inject 8 units three times daily before meals subcutaneously (under the skin) plus sliding scale order (if necessary, per blood sugar reading). R5's sliding scale order indicated if blood glucose less than 149, give 0 units; 150-190, give 2 units; 191-230, give 4 units; 231-270, give 6 units; 271-310, give 8 units; 311-350, give 10 units; 351-400, give 12 units. On September 18, 2023, at 11:41 a.m. the surveyor observed ULP-K obtain R5's blood sugar and administer R5's Humalog KwikPen insulin. The insulin pen did not include a date when opened, though it had a label attached to the pen to fill in the information. When interviewed immediately following the observation, ULP-K stated he had not been trained to date insulin pens when opened. On September 20, 2023, at 10:07 a.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated expectation was to date insulin pens when opened and further stated staff had been trained to do this. The licensee's Insulin Administration Policy for Assisted Living reviewed June 30, 2023, did not include dating insulin pens when opened. The manufacturer package inserts for the	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/20/2023
NAME OF PROVIDER OR SUPPLIER THE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007			
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01890	Continued From page 26 Humalog KwikPen revised July 2023, indicated: Throw away the Humalog pen you are using after 28 days, even if it still has insulin left in it. R6 R6's Service Plan dated July 30, 2021, indicated R6 received services including medication administration. R6's physician orders dated September 15, 2023, included diclofenac sodium 1% gel (used to relieve pain and swelling from various mild to moderate painful conditions), apply four grams topically four times a day for back/joint/right knee pain. On September 18, 2023, at 11:21 a.m. ULP-K was observed administering medication to R6 including diclofenac sodium 1% gel. The prescription label on the gel indicated to apply two grams topically to lower back four times a day. The prescription label did not match the current physician order. On September 20, 2023, at 10:07 a.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A observed R6's diclofenac sodium 1% gel prescription label and compared with R6's current physician orders and stated there was a discrepancy and the nurse should have been notified. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy revised June 30, 2023, indicated: 2. Medications, treatment and therapy always need to be administered according to the "6 Rights" a. Right person b. Right medication, treatment, or therapy	01890			

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01890	Continued From page 27 c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops, etc.) f. Right chart/record to document that the medication, treatment, and therapy was taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to	{01940}			

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{01940}	Continued From page 28 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R9, R13). 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 September 18, 2023, at 10:00 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided treatment management services to their residents. R9 R9 had a diagnosis congestive heart failure (when the heart muscle doesn't pump blood as well as it should) and hypertension (high blood	{01940}			

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{01940}	Continued From page 29 pressure). R9's Service Plan dated February 1, 2022, and Care Plan dated April 24, 2023, identified R9 required assistance with medication administration, transfers, wheel chair mobility, toileting, and bathing. R9's service plan and care plan lacked any identified treatments. R9's individualized treatment and therapy management plan dated September 18, 2023, (after the survey entrance), indicated R9 received assistance with oxygen at 2 liters (L)/minute continuously. R9's records lacked a treatment management plan to include the following required content for the use of oxygen: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On September 20, 2023, at 11:30 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R9's record lacked a treatment management plan to include all the required content as noted above. R13 R13 had a diagnosis of diabetes. R13's service plan dated August 31, 2023, indicated R13 received assistance with blood glucose checks four times daily.	{01940}			

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{01940}	Continued From page 30 R13's individualized treatment and therapy management plan dated August 31, 2023, indicated R13 received assistance with blood glucose checks four times daily and as needed. R13's records lacked a treatment management plan to include the following required content for blood glucose checks: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On September 19, 2023, at 9:57 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R13's record lacked a treatment management plan to include all the required content as noted above. The licensee's Individualized Medication, Treatment & Therapy Management Plans policy revised June 20, 2023, indicated: Medication, treatment, and therapy management plans will be current and updated when there are changes. No further information was provided.	{01940}			
{02170} SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the	{02170}			

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{02170}	Continued From page 31 following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to develop an individualized activity plan based on the evaluation, for one of	{02170}			

Minnesota Department of Health

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{02170}	Continued From page 32 five residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee had an assisted living with dementia care license effective June 1, 2023. R2 was admitted and started receiving assisted living services on January 19, 2023, with a diagnosis of dementia. R2's Service Plan dated January 19, 2023, indicated R2 received assistance with medication administration. R2's record lacked an individualized written activity evaluation that addressed: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, R2's record lacked the development of an individualized activity plan based on the activity evaluation.	{02170}			

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{02170}	Continued From page 33 On September 20, 2023, at 11:32 a.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R2 did not have a completed activity assessment/plan with the required components. The licensee's Activity Daily and Preference Assessment policy dated June 2023, noted a comprehensive activity profile would be obtained with an assessment of resident past and current activity interests. No further information provided.	{02170}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 14, 2023

Licensee
The Meadows
1761 Eagle View Circle
Albert Lea, MN 56007

RE: Project Number(s) SL32452015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 23, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized, flowing script.

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

PMB

Minnesota Department of Health

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32452015 On June 20, 2023, through June 23, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 33 active residents; 32 receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250			

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 20,	0 250			

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0 250	Continued From page 3 2023, at 10:00 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page five and six of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04	0 250			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2023
NAME OF PROVIDER OR SUPPLIER THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007		
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0 250	Continued From page 4 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250			

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0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. honest - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorized agent on May 10, 2023. The licensee had an assisted living license issued on June 1, 2023, with an expiration date of May 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff. (4) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (5) 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,	0 250			

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0 250	Continued From page 6 managed, and communicated to staff and other health care providers as appropriate; (6) 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; (7) medication and treatment management; (8) delegation of tasks by registered nurses or licensed health professionals; As a result of this survey, the following orders were issued 0630, 0660, 1290, 1360, 1370, 1500, 1610, 1620, 1710, 1750, 1760, 1770, and 1940 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	0 470			

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0 470	Continued From page 7 situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting the licensee's residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a licensee'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 held an assisted living with dementia care license, and was licensed for a capacity of 36 residents, and had a current census of 33 residents.	0 470			

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0 470	Continued From page 8 The licensee failed to develop and implement a staffing plan for determining it's staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. On June 20, 2023, at 10:00 a.m. during the entrance conference, the facility staffing plan was requested. Throughout the survey and again by email on June 22, 2023, at 4:38 p.m. the staffing plan and review dates were requested. On June 23, 2023, at 8:00 a.m. the facility provided the direct-care staffing plan; however, it lacked review dates. On June 23, 2023, at approximately 8:00 a.m. assistant administrator (AA)-G stated she was unable to locate review dates for the staffing plan. The licensee's Direct-Care Staffing Plan dated August 2022, identified the staffing plan would provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven-days a week. The policy further indicated the staffing plan would be evaluated for the appropriate levels of staffing in the facility and revised as needed at a minimum of two times per year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480			

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0 480	Continued From page 9 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 21, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person	0 630			

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0 630	Continued From page 10 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for one of three residents (R3). 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: R3 had a diagnosis of dementia. R3's Service Plan dated May 19, 2022, indicated R3 received services which included medication administration, dressing, and bathing assist. R3's Individual Abuse Prevention Plan (IAPP) and Assessment for Client Vulnerability, Safety and Risk to Others dated May 19, 2023, included an assessment of the resident's susceptibility to abuse by other individuals and an assessment of the resident's risk of abusing other vulnerable adults. However, the assessment lacked statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.	0 630			

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0 630	Continued From page 11 On June 22, 2023, at 3:42 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated all IAPPs should have specific interventions listed for each vulnerability identified. CNS/LALD-A stated the required components were lacking from R3's assessment. The licensee's Vulnerable Adult Reporting and Investigation Policy dated revised May 2023, lacked the development and implementation of an individual abuse prevention plan for each vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660			

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0 660	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated May 25, 2022, indicated the licensee was a low risk. On June 21, 2023, at 11:54 a.m. ULP-E was observed administering insulin to R1. ULP-E's employee record showed ULP-E had a start date of May 22, 2023. ULP-E's employee's record contained a TB Baseline Screening Tool for Health Care Workers form dated May 22, 2023. The form indicated ULP-E had a first-step TST administered on May 24, 2023, and read on May 26, 2023. The form did not include evidence that a second step TST	0 660			

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0 660	Continued From page 13 had been completed. On June 23, 2023, at 10:00 a.m. licensed practical nurse (LPN)-B confirmed ULP-E's employee file did not include evidence a second TST had been completed. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (health care workers) (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see whether a person has been infected with the bacteria causing TB). The 2-step TST identified as: Procedure used for the baseline skin testing of persons who will receive serial TSTs (e.g., HCWs and residents of long term-care facilities) to reduce the likelihood of mistaking a boosted reaction for a new infection. If an initial TST result is classified as negative, a second step of a two-step TST should be administered 1-3 weeks after the first TST result was read. If the second TST result is positive, it probably represents a boosted reaction, indicating infection most likely occurred in the past and not recently. If the second TST result is also negative, the person is classified as not infected. The licensee's TB Abatement policy reviewed October 2018, indicated all employees would	0 660			

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0 660	Continued From page 14 have, at no cost to them, a baseline two-step (TST) or one IGRA (TB blood test) evaluated and documented upon initiation of employment by a nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680			

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0 680	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to evaluate it's missing person policy at least quarterly and post an emergency disaster plan prominently. This had the potential to affect all residents, staff, and visitors of the facility. 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: MISSING RESIDENT PLAN/POLICY The licensee's Missing Resident policy dated August 2022, was included in the EP plan. The policy lacked evidence the assisted living director and clinical registered nurse reviewed or updated the policy and documented any changes, at least quarterly as required. On June 20, 2023, at 2:45 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the missing resident plan was last reviewed August 2022. CNS/LALD-A stated she was not aware the missing resident plan needed to be reviewed quarterly. EMERGENCY DISASTER PLAN POSTED The licensee failed to prominently post the emergency disaster plan.	0 680			

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0 680	Continued From page 16 On June 20, 2023, at 11:00 a.m. observation of the facility identified no posted facility emergency disaster plan. On June 21, 2023, at 2:45 p.m. CNS/LALD-A stated the campus had multiple emergency preparedness plan binders, but this was not posted prominently anywhere in the facility. CNS/LALD-A stated she was unaware of the requirement. The licensee's Plans for Emergencies and Natural Disasters policy dated August 1, 2021, noted the facility would post an emergency disaster plan prominently. The policy lacked information regarding the review of the missing resident policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, the licensee failed to maintain the physical environment, including	0 800			

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0 800	Continued From page 17 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings include: On facility tour with the Director of Environmental Services (DES)-D, between approximately 9:30 AM and 11:30 AM on June 21, 2023, it was observed that the laundry rooms (2) needed maintenance to remove accumulations of lint. This was specifically noted in the areas behind the dryers and other hard-to-reach areas of the room. This deficient condition was visually verified by DES-D accompanying on the tour. Additionally, within the memory care area of the facility, it was observed that potentially dangerous utensils were kept in an unsecured drawer within the kitchen. This deficient condition was visually verified by DES-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810			

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0 810	Continued From page 18 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements and	0 810			

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0 810	Continued From page 19 failed to provide training to residents capable of assisting in their own evacuation. This had the potential to affect all staff, residents, 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). Findings include: A record review and interview were conducted on June 21, 2023, between approximately 11:30 a.m. and 12:00 p.m. with the Director of Environmental Services (DES)-D on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review indicated that the fire safety and evacuation plan did not have provisions for sheltering in place for the residents. Additionally, training on the proper actions to take in the event of a fire was not provided annually to residents capable of self-evacuation. During the interview, documents were requested for a sheltering in place policy and annual resident training, but none were provided. This deficient condition was verified by DES-D during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			

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01060	Continued From page 20	01060			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060			

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01060	Continued From page 21 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's diagnoses included diabetes and generalized muscle weakness. R1's Service Plan dated July 31, 2021, indicated R1 received assistance with medication administration (insulin only), TED (thrombo-embolic deterrent) sock (compression socks used to increase circulation to prevent swelling) to left leg, wound care to right lower leg per physician's orders, and laundry. R1's Interdisciplinary Progress Notes (IPN) dated May 29, 2023, at 9:37 a.m. indicated R1 was complaining of shortness of breath, constipation, feeling sweaty, faint, and coughing up a lot of phlegm. R1 requested to be transferred to	01060			

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01060	Continued From page 22 emergency room by ambulance. IPN dated May 29, 2023, at 12:35 p.m. identified R1 had been admitted to the hospital with an infection. IPN dated June 1, 2023, at 3:24 p.m. indicated resident returned from the hospital (three days later). R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation. - the name and contact information for the location to which the resident has been relocated and any new service provider. - contact information for the Office of Ombudsman for Long-Term Care. - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known. - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On June 21, 2023, at 2:00 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated no written notice was provided to R1, or any other residents that have had an emergency relocation. CNS/LALD-A stated she was not aware of the requirement. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060			

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01290	Continued From page 23	01290			
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received an affiliation with the assisted living license for one of two employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on November 2, 2021, to	01290			

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01290	Continued From page 24 provide direct care and services to the licensee's residents under the assisted living with dementia care license. On June 21, 2023, at 7:30 a.m. the surveyor observed ULP-F administer medications to R3. ULP-F's employee record contained a background study dated April 21, 2022, for a separate location operated by the licensee's owner. ULP-D's employee record lacked evidence the licensee affiliated a background study for their license. On August 31, 2023, at 8:58 a.m. human resources director (HRD)-I confirmed ULP-D's background study had not been affiliated with the assisted living with dementia care facility license. The licensee's Criminal Background Check policy revised June 2016, indicated for every employee the licensee will submit a criminal background check to the Department of Human Services, and they will determine any disqualifications. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01360 SS=D	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be	01360			

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01360	Continued From page 25 conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations of unlicensed personnel (ULP) providing assisted living services were conducted by a registered nurse (RN) for one of two unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E began providing direct care services for the licensee on May 22, 2023. On June 21, 2023, at 11:54 a.m. ULP-E was observed administering insulin to R1. ULP-E lacked an employee record with evidence the employee had been trained by a RN in the following areas: - documentation requirements for all services provided;	01360			

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01360	Continued From page 26 - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming including hair care, bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; awareness of confidentiality and privacy; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; - awareness of commonly used health technology equipment and assistive devices; observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident;	01360			

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01360	Continued From page 27 - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. On June 23, 2023, at 8:58 a.m. human resources director (HRD)-I confirmed the licensed practical nurse manager was responsible for conducting the training and competency testing for new ULP. On June 23, 2023, at 10:00 a.m. licensed practical nurse (LPN)-B confirmed the LPNs were responsible for training and competency testing for the new employees. LPN-B stated the previous clinical nurse supervisor (CNS) conducted competency training/testing for the ULP, but the current CNS did not. The licensee's Unlicensed Personnel - Training and Competency Evaluation policy revised May 2023, indicated: Unlicensed home care personnel will meet all orientation and training requirements and will be determined to be competent to perform all assigned tasks by the RN or by other Licensed Health Professional, when appropriate, before unlicensed personnel may provide any service to a home care client. The licensee's Training Unlicensed personnel for Medication Administration policy revised September 24, 2022, indicated: Before the RN delegates the task of assistance with self-administration of medications or the task of medication administration, the RN must instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks. No further information was provided.	01360			

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01360	Continued From page 28	01360			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's	01370			

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01370	Continued From page 29 family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations of unlicensed personnel (ULP) providing assisted living services were conducted by a registered nurse (RN) for one of two (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E began providing direct care services for the licensee on May 22, 2023, under the assisted living with dementia care licensure. ULP-E's employee record lacked evidence the employee had been trained by a RN in the following areas: - training on the prevention of falls for providers working with the elderly or individuals at risk of falls. On June 23, 2023, at 8:58 a.m. human resources director (HRD)-I confirmed ULP-E's record did	01370			

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01370	Continued From page 30 not include the above required training. The licensee's Unlicensed Personnel - Training and competency Evaluation policy indicated: 3. Training content for Unlicensed Personnel and competency Evaluation. Following are the required training topics for unlicensed personnel, with notation regarding the type of competency evaluation that is required. f. training on the prevention of falls for providers working with the elderly or individuals at risk of falls (written or oral test required). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500			

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01500	Continued From page 31 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01500			

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01500	Continued From page 32 licensee failed to ensure annual training included all required topics for each 12 months of employment for one of four employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on November 2, 2021, to provide direct care services under the licensee's assisted living with dementia care license. ULP-F's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On June 23, 2023, at 10:00 a.m. licensed practical nurse (LPN)-B stated the department heads review the facility's policies and procedures, but the rest of the staff do not. LPN-B stated the clinical nurse supervisor will update the LPNs if there are any policy changes and they will then pass the information on to the ULP. LPN-B confirmed having no documentation to support this. The licensee's undated, Annual Training	01500			

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01500	Continued From page 33 Requirement for Dual Caregiver Employees (Comprehensive Home Care & Assisted Living/Memory Care) included: Policies and Procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of one resident (R2) prior to initiation of services.	01610			

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01610	Continued From page 34 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: R2 was admitted on January 19, 2023, and received services under the licensee's assisted living with dementia care license. R2 had a diagnosis of dementia. R2's Service Plan dated January 19, 2023, indicated R2 received assistance with medication administration, weekly medication set-up, laundry, and housekeeping. R2's record included a Baseline Assessment dated January 23, 2023. No assessment was completed prior to or upon initiation of services on January 19, 2023. On June 22, 2023, at 3:47 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R2's admission assessment was not completed when required. The licensee's Nursing Assessment policy dated June 1, 2023, indicated a registered nurse would complete a baseline assessment on admission. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01610			

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01610	Continued From page 35 (21) days	01610			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for one of three residents (R3) and failed to conduct a change of condition assessment following hospitalization for one of	01620			

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01620	Continued From page 36 one resident (R1). 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: R3 R3's Service Plan dated May 19, 2022, indicated R3 received services with medication administration and weekly bathing. R3's last three assessments were requested. Assessments dated November 17, 2022, February 16, 2023, and May 19, 2023, were provided. The February 16, 2023, assessment was 91 days from the last date of the assessment, exceeding 90 calendar days. In addition, the May 19, 2023, assessment was 92 days from the last date of the assessment, exceeding 90 calendar days. On June 22, 2023, at 9:58 a.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated she was "off base" with the assessments and aware R3's assessments had not been completed within 90 days as required. R1 R1's Service Plan dated July 31, 2021, indicated R1 received assistance with medication administration (insulin only), TED (thrombo-embolic deterrent) sock (compression	01620			

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01620	Continued From page 37 socks used to increase circulation to prevent swelling) to the left leg, wound care to the right lower leg per physician's orders, and laundry. R1's Interdisciplinary Progress Notes (IPN) dated May 29, 2023, at 9:37 a.m. indicated R1 was complaining of shortness of breath, constipation, feeling sweaty, faint, and coughing up a lot of phlegm. R1 requested to be transferred to emergency room by ambulance. IPN dated May 29, 2023, at 12:35 p.m. identified R1 had been admitted to the hospital with an infection. IPN dated June 1, 2023, at 3:24 p.m. indicated resident returned from the hospital (three days later). R1's record did not include a change of condition assessment by the RN upon return from the hospital. On June 22, 2023, at 3:40 p.m. CNS/LALD-A stated R1 would have required a change in condition assessment upon R1's return from hospital on June 1, 2023, but was unable to locate it or provide it to the surveyor. The licensee's Nursing Assessment policy dated June 1, 2023, noted residents would receive services with professional nursing assessments on a regular basis and in the event of health status changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01650 SS=C	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650			

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01650	Continued From page 38 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the correct required content for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	01650			

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01650	Continued From page 39 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: R1 R1 had a diagnosis of diabetes. R1's Service Plan dated July 31, 2021, indicated R1 received assistance with medication administration (insulin only), TED (thrombo-embolic deterrent) sock (compression socks used to increase circulation to prevent swelling) to the left leg, wound care to the right lower leg per physician's orders, and laundry. The service plan included a registered nurse (RN) assessment would be conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. R2 R2 had a diagnosis of dementia. R2's Service Plan dated January 19, 2023, indicated R2 received assistance with medication administration, weekly medication set-up, laundry, and housekeeping. The service plan included a RN assessment would be conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. R3	01650			

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01650	Continued From page 40 R3 had a diagnosis of dementia. R3's Service Plan dated May 19, 2022, indicated R3 received services with medication administration and weekly bathing. The service plan included a RN assessment would be conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. On June 22, 2023, at approximately 9:54 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the above required content was incorrect in the service plan, and reflective of previous home care statutes. CNS/LALD-A also said the same service plan format is utilized for all residents. The licensee's Contents of Service Plans policy dated reviewed May 2023, noted the service plan would include the schedule and methods of monitoring reviews or re-assessments of the client, including if the method is face to face or via telemonitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues	01710			

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01710	Continued From page 41 that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of three residents (R1). 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 June 20, 2023, at 10:00 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided medication management services to the residents at the facility. R1 had a diagnosis of diabetes. R1's Service Plan dated July 31, 2021, indicated R1 received services which included medication administration (insulin only). R1's prescriber's orders dated June 9, 2023, included two injectable insulins, one oral	01710			

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01710	Continued From page 42 anti-diabetic medication, one uric acid reducer, one for allergies, one minor pain reliever, three anti-hypertensive medications, two diuretics, and four supplements. On June 21, 2023, at 11:54 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's insulin. R1's Medication Management Plan was last reviewed July 31, 2021. R1's record lacked evidence the RN conducted a review of all medications the residents were known to be taking include a review of the side effects and contraindications annually. On June 21, 2023, at 1:22 p.m. CNS/LALD-A stated R1's medication management plan had not been reassessed by the RN annually. The licensee's Medication Management Services policy dated June 2023, indicated the RN would develop an individualized medication management plan for each client receiving any type of medication management services, consistent with current practice standards and guidelines. The policy did not address the frequency of the review. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated	01750			

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01750	Continued From page 43 to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (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; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-E) administered insulin according to manufacturer instructions. 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 R1 had a diagnosis of diabetes. R1's Service Plan and Individualized Medication Management Plan dated July 31, 2021, indicated R1 received assistance with medication administration (insulin only). R1's prescriber orders dated October 20, 2022, included Humalog KwikPen (a prefilled pen	01750			

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01750	Continued From page 44 containing injectable medication for diabetes) 100 units/1 milliliter (ml) inject 4 units into skin three times a day before meals. On June 21, 2023, at 11:54 a.m. the surveyor observed unlicensed personnel (ULP)-E to sanitize hands, apply gloves, obtain R1's Humalog KwikPen, removed the cap, and proceeded to apply a new needle. ULP-E did not cleanse the end of the insulin pen prior to applying the needle. ULP-E then dialed the Humalog KwikPen insulin prefilled pen to four units and administered to R1's left upper arm. ULP-E stated she had not used an alcohol wipe to cleanse the insulin pen prior to applying the needle and indicated she should have. ULP-E further confirmed the Humalog KwikPen had not been primed first by dialing it to two units and ejecting the medication prior to dialing the prescribed four units. ULP-E further stated she was not aware of that step. ULP-E stated she had been trained to administer insulin with a prefilled pen by a registered nurse (RN). R5 R5's diagnoses included diabetes and multiple sclerosis (disabling disease of the brain and spinal cord. R5's Service Plan dated July 31, 2021, indicated R5 received assistance with medication administration. R5's prescriber orders dated May 22, 2023, included insulin lispro Kwikpen 100 units/1 ml inject eight units into skin three times a day plus sliding scale insulin 150-190= two units, 191-230= four units, 231-270= six units, 271-310= eight units, 311-350= ten units, 351-400= 12 units.	01750			

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01750	Continued From page 45 Maximum daily dose 69 units. On June 21, 2023, at 12:19 p.m. the surveyor observed ULP-E to sanitize hands, apply gloves, obtain R5's insulin lispro KwikPen, removed the cap, cleansed the end of the insulin pen with an alcohol wipe, and applied the new needle. ULP-E stated R5's blood sugar reading was 354, so would be receiving a total of 20 units. ULP-E then dialed the insulin lispro KwikPen prefilled pen to 20 units and administered into R5's abdomen. ULP-E further stated she did not prime the insulin lispro KwikPen by dialing it to two units and ejecting the medication prior to dialing the prescribed 20 units. ULP-E again stated she was not aware of that step. On June 21, 2023, at 1:52 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated insulin should be administered according to manufacturer's recommendations, including cleansing the end of the insulin pen prior to applying the needle and priming the insulin pen by dialing the pen to two units, expressing the insulin, and dialing to the prescribed dose. CNS/LALD-A stated this is how she trained staff to administer insulin injections. The manufacturer's instructions for use of the Humalog KwikPen dated revised April 2020, instructed to pull the pen cap straight off, wipe the rubber seal with an alcohol swab, push capped needle straight onto the pen and twist the needle on until it is tight. The instructions further instructed to prime before each injection. "Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little	01750			

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01750	Continued From page 46 insulin. To prime your pen, turn the dose knob to select two units. Hold your pen with the needle pointing up, tap the cartridge holder gently to collect bubbles at the top. Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps no more than four times." The manufacturer's instructions for us of the insulin Lispro KwikPen dated revised June 2020, instructed to prime before each injection. "Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to select two units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps no more than four times." The licensee's undated, insulin pens skill competency procedure included: 6. Remove the pen cap and clean the tip with sterile alcohol wipe. 7. Attach a new needle to the pen. 8. Prime the pen and dial up the correct dose. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01750			

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01750	Continued From page 47 days	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-F) administered medications as prescribed with medication administration. 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:	01760			

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01760	Continued From page 48 R3 had a diagnosis of dementia. R3's Service Plan and Individualized Medication Management Plan dated May 19, 2022, indicated R3 received medication administration. R3's prescriber's orders dated June 16, 2023, included orders for Aspercreme (topical pain relief) 4% cream apply thin layer to RIGHT shoulder affected areas for pain every 6-8 hours not to exceed three applications in 24 hours. R3's medication administration record (MAR) dated June 2023, included an order for Aspercreme 4% cream apply thin layer to RIGHT shoulder affected areas for pain every 6 to 8 hours not to exceed three applications in 24 hours. On June 21, 2023, at 7:30 a.m. the surveyor observed unlicensed personnel (ULP)-F prepare R3's medication for administration. ULP-F grabbed the tube of R3's Aspercreme and after comparing the Aspercreme with R3's MAR, sanitized hands and applied gloves. ULP-F then applied a thin layer of the Aspercreme to R3's LEFT shoulder. The MAR order was verified by the surveyor which identified Aspercreme 4% cream apply thin layer to RIGHT shoulder. ULP-F stated the MAR did not match where the Aspercreme had been applied indicating the nurse had "messed it up" when entering the order as R3 wanted the Aspercreme to her LEFT shoulder. On June 21, 2023, at 1:23 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the ULP should have followed the orders as reflected on MAR.	01760			

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01760	Continued From page 49 CNS/LALD-A further stated if R3 wanted the Aspercreme to her LEFT shoulder than the ULP should have reported that to the nurse. The licensee's Administration of Medication by Unlicensed Personnel policy revised September 24, 2022, noted ULP that satisfy the training requirement, have been determined competent to follow the procedures, and have been delegated the responsibility by the RN may administer medications by following the RN's written instruction for administering the medications to the client. Medications always need to be administered according to the "6 Rights": Right person Right medication Right time Right route Right dose Right chart/record to document that the medication was taken No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01770			

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01770	Continued From page 50 review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on June 20, 2023, at 10:00 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided medication management services to their residents, including medication setup. R2's Service Plan dated January 19, 2023, indicated R2 received assistance with medication administration and weekly medication set-up. R2's prescriber orders dated January 26, 2023, included one for hypothyroidism, three supplements, and one mild pain reliever. On June 21, 2023, at 12:40 p.m. licensed practical nurse (LPN)-J was observed to complete a medication set-up into mediminder (medication dispenser) for R2. R2's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration.	01770			

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01770	Continued From page 51 On June 21, 2023, at 1:07 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated documentation included that a medication setup had been completed; however, it lacked what medications, quantity of dose, times, or route. CNS/LALD-A further stated this was the process used for all medication set ups. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy	01940			

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01940	Continued From page 52 received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1). 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 June 20, 2023, at 10:00 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided treatment management services to their residents, including compression stockings. R1 had a diagnosis of diabetes. R1's Service Plan dated July 31, 2021, indicated R1 received assistance with TED (thrombo-embolic deterrent) sock (compression	01940			

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01940	Continued From page 53 socks used to increase circulation to prevent swelling) to left leg. R1's Care Plan dated June 18, 2023, identified R1 required assistance with TED hose. Staff assist in placing this on left lower leg every morning and remove it every evening. On June 20, 2023, at 2:00 p.m. R1 was observed to have a TED sock on left lower leg. R1 stated staff applied the stocking every morning and removed in the evening. R1's prescriber orders dated June 9, 2023, included an order for support sock (compression stocking) apply to left lower leg in the morning, remove at night. R1's Treatment Record dated May 22, 2023, through June 20, 2023, included staff initials that support sock was applied to left lower leg in the morning and removed at bedtime. R1's records lacked a treatment management plan to include the following required content for the use of compression stockings: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On June 22, 2023, at 4:15 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R1's record lacked a treatment management plan to include all the	01940			

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01940	Continued From page 54 required content as noted above. The licensee's Individualized Medication, Treatment & Therapy Management Plans policy dated revised June 20, 2023, indicated a registered nurse (RN) would develop a treatment management plan for each resident receiving treatment services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and	02110			

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02110	Continued From page 55 how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings included: The licensee had an assisted living with dementia care license effective June 1, 2023. R1, R2, and R3's records lacked documentation	02110			

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02110	Continued From page 56 for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On June 20, 2023, at 2:38 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated none of the current residents had received the required policies. CNS/LALD-A further stated she was not aware of the requirement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	02110			

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02110	Continued From page 57 (21) days	02110			
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and	02170			

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02170	Continued From page 58 (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions, and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R2, R3). 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 had an assisted living with dementia care license effective June 1, 2023. R2 R2 was admitted and started receiving assisted living services on January 19, 2023, with a diagnosis of dementia. R2's Service Plan dated January 19, 2023, indicated R2 received assistance with medication administration, weekly medication set-up, laundry, and housekeeping. R3 R3 was admitted and started receiving assisted living services on May 19, 2022, with a diagnosis of dementia.	02170			

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NAME OF PROVIDER OR SUPPLIER THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007		
(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
02170	Continued From page 59 R3's Service Plan dated May 19, 2022, indicated R3 received services with medication administration and weekly bathing. R2 and R3's records lacked an individualized written activity evaluation that addressed: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, R2 and R3's record lacked the development of an individualized activity plan based on the activity evaluation. On June 23, 2023, at 3:50 p.m. activity director (AD)-H stated she does not do any type of assessment for the residents. AD-H stated she was not aware of the requirement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2023
NAME OF PROVIDER OR SUPPLIER THE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
03090	Continued From page 60 subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure signage was posted at the main entry of the building of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on June 20, 2023, at 11:01 a.m. the surveyor observed the front entrance and entryway of the facility with licensed practical nurse (LPN)-B. No posting for electronic monitoring was observed. On June 20, 2023, at 11:16 a.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated there used to be a posting in the entryway, but someone must have taken it down. CNS/LALD-A confirmed the licensee lacked the proper signage with the statutory language. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2023
NAME OF PROVIDER OR SUPPLIER THE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007			
(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



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

Type: Full
Date: 06/21/23
Time: 09:08:13
Report: 8044231199

Food and Beverage Establishment Inspection Report

Page 1

Location:

The Meadows - Assisted Living
1761 Eagle View Circle
Albert Lea, MN56007
Freeborn County, 24

Establishment Info:

ID #: 0038610
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073738226
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 37.6 Degrees Fahrenheit - Location: Cut melon in upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37.0 Degrees Fahrenheit - Location: Upright
Violation Issued: No

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

HRD inspection conducted with Nursing Evalulator, Susan Kalis. Inspection report reviewed on site with Director of Culinary Services, Carrie.

Type: Full
Date: 06/21/23
Time: 09:08:13
Report: 8044231199
The Meadows - Assisted Living

Food and Beverage Establishment Inspection Report

Page 2

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 8044231199 of 06/21/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____


Inspector signed for Carrie

Signed: _____


Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us



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

Type: Full
Date: 06/21/23
Time: 09:17:53
Report: 8044231200

Food and Beverage Establishment Inspection Report

Page 1

Location:

The Meadows - Main Kitchen
1761 Eagle View Circle
Albert Lea, MN56007
Freeborn County, 24

Establishment Info:

ID #: 0038610
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073738226
ID #:

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

The following orders were issued during this inspection.

3-500A Microbial Control: cooling

3-501.14A **** Priority 1 ****

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

Beef roast cooled on 6/20 measured at 45 degrees F.

Roast sliced into thin portions and cooled rapidly while on site.

Comply By: 06/21/23

3-500A Microbial Control: cooling

3-501.15A **** Priority 2 ****

MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.

Beef cooled in whole roast form instead of cutting into 2 inch portions.

Comply By: 06/21/23

Type: Full
Date: 06/21/23
Time: 09:17:53
Report: 8044231200
The Meadows - Main Kitchen

Food and Beverage Establishment Inspection Report

Page 2

3-500A Microbial Control: cooling

3-501.15B **** Priority 2 ****

MN Rule 4626.0390B Loosely cover containers of cooling food and arrange in cold holding equipment in a manner to maximize heat transfer through the container walls.

Taco meat cooled in covered containers.

Comply By: 06/21/23

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

All handwashing sinks in kitchen and dish room not sealed to wall.

Comply By: 07/21/23

Surface and Equipment Sanitizers

Hot Water: = at 166.5 Degrees Fahrenheit

Location: Dishwasher

Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit

Location: Dispenser

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooling

Temperature: 45.1 Degrees Fahrenheit - Location: Beef roast

Violation Issued: Yes

Process/Item: Cold Holding

Temperature: 38.6 Degrees Fahrenheit - Location: Taco meat in WIC

Violation Issued: No

Process/Item: Cold Holding

Temperature: 35.0 Degrees Fahrenheit - Location: WIC

Violation Issued: No

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

HRD inspection conducted with Nursing Evalulator, Susan Kalis. Inspection report reviewed on site with Director of Culinary Services, Carrie.

Type: Full
Date: 06/21/23
Time: 09:17:53
Report: 8044231200
The Meadows - Main Kitchen

Food and Beverage Establishment Inspection Report

Page 3

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 8044231200 of 06/21/23.

Certified Food Protection Manager Carrie A. Seath

Certification Number: FM91652 Expires: 11/29/23

Inspection report reviewed with person in charge and emailed.

Signed: 
Inspector signed for Carrie

Signed: 
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us



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

Type: Full
Date: 06/21/23
Time: 08:39:04
Report: 8044231198

Food and Beverage Establishment Inspection Report

Page 1

Location:

The Meadows - Memory Care
1761 Eagle View Circle
Albert Lea, MN56007
Freeborn County, 24

Establishment Info:

ID #: 0038610
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073738226
ID #:

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

The following orders were issued during this inspection.

3-800 Highly Susceptible Populations

3-801.11B **** Priority 1 ****

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

Egg bake prepared using unpasteurized eggs.

Comply By: 06/21/23

5-200C Plumbing: Maintenance, fixture location

5-205.11AB **** Priority 2 ****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

Dishes in handwashing sink.

Comply By: 06/21/23

7-100 Toxic Labeling

7-102.11 **** Priority 2 ****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

Sanitizer spray bottle not labeled.

Label added while on site.

Type: Full
Date: 06/21/23
Time: 08:39:04
Report: 8044231198
The Meadows - Memory Care

Food and Beverage Establishment Inspection Report

Page 2

Comply By: 06/21/23

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Spray bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 36.2 Degrees Fahrenheit - Location: Ham in upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36.0 Degrees Fahrenheit - Location: Upright
Violation Issued: No

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

HRD inspection conducted with Nursing Evalulator, Susan Kalis. Inspection report reviewed on site with Director of Culinary Services, Carrie.

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 8044231198 of 06/21/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: 
Inspector signed for Carrie

Signed: 
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us