Electronically Delivered

November 17, 2021

Administrator
Cottagewood Senior Communities
300 Bunting Lane
Mankato, MN 56001

RE: Project Number(s) SL20394015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 30, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

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

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

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

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

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20394	A. BUILDING: _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGEWOOD SENIOR COMMUNITIES	300 BUNTING LANE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL20394015 On September 28, 2021 through September 30, 2021, surveyors of this Department's staff visited the above Assisted Living with Dementia Care licensed provider, and the following correction orders are issued. At the time of the survey, there were 14 current residents receiving services under the assisted living with dementia care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 according to the Minnesota Food Code. This had the potential to affect all 14 residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated September 13, 2021. TIME PERIOD FOR CORRECTION: Twenty-one	0 480		

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

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0 680	Continued From page 3 potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan, provided to the surveyors, was a number of documents and policies contained in a three-ringed binder. The licensee's plan lacked the following required content: - current, all-hazards approach facility assessment; - description of the population served by licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - subsistence needs for staff and residents during emergency situation; - procedure for tracking staff and residents; - development of all policies/procedures, based on assessment; and additional policies for: - sheltering in place; - handling and use of volunteers; - development of a communication plan, including primary and alternate means for communication; - methods for sharing information/family notifications; - EP training and testing program;	0 680		

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0 680	Continued From page 4 - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On September 30, 2021, at approximately 9:28 a.m. the surveyor reviewed the emergency preparedness plan and content with the executive director (ED). She confirmed a facility risk assessment and a description of residents served had not been completed. The EP binder lacked all the required content and would need to be updated. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
01770 SS=E	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 review, the licensee failed to ensure documentation of medication setup included all required content for two of two residents (R5, R6) with records reviewed This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01770		

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cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

During the entrance conference on September 28, 2021, at approximately 10:24 a.m. licensed practical nurse (LPN)-A stated the licensee provided medication management services which included medication setup by a licensed nurse for later administration.

R5's and R6's records lacked documentation of medication setup to include: documentation of the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration and the name of the person completing medication setup.

R5
R5's diagnoses included, but were not limited to, Alzheimer's disease, insomnia, anxiety and depression.

R5's Individualized Service Plan, dated effective September 30, 2021, indicated the client received medication management services.

R5's Medication Management Plan dated May 5, 2021, indicated the client's medications would be set up by a licensed nurse. In addition, controlled substances (medications) would be provided in limited quantities after licensed nurse set up, and stored separately from other medications. R5's plan indicated staff will document the administration of medications through the

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electronic medication administration record (eMAR). The plan did not include information about documentation of medication set up ahead of time for later administration.

R5's prescriber's orders dated August 4, 2021, included but were not limited to, acetaminophen (pain reliever); divalproex sodium (indicated for mood); methadone (a controlled medication, indicated for chronic pain); Olanzapine (antidepressant); and lorazepam (a controlled medication, indicated for anxiety).

On September 29, 2021, at approximately 7:44 a.m. unlicensed personnel (ULP)-C entered the locked medication room and began to set up R5's morning medications. Included among R5's medications was methadone (the oral medication was in a pre-filled syringe) which ULP-C retrieved from a small plastic box, stored in a locked refrigerator. R5's methadone box was labeled with the dosage: 10 mg/ml (milligrams per milliliter) dose of 0.2 ml (2 mg); and directed: Give 0.2 ml (2 mg) by mouth every 8 hours scheduled, Not a PRN (as needed). 12 a.m., 8 a.m., 4 p.m. ULP-C compared the number of doses/syringes in the box to the count in the narcotic record book, and the counts matched. ULP-C administered the methadone along with R5's remaining morning medications in the resident's room, and returned to the medication room where ULP-C documented the administration.

Later, at approximately 8:15 a.m. ULP-C showed the surveyor the eMAR where she documented R5's medications. ULP-C was asked if there was a record in R5's eMAR that showed who set up the methadone ahead of time, and ULP-C stated that was documented in the "narc book" (the

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black, narcotic record). ULP-C stated "the only thing in the eMAR would be me signing off that I gave R5 his medications." ULP-C also stated the nurses set up the medication by pre-filling the syringes each with one dose.

R5's medication administration records (MAR) from August and September 2021, were reviewed and they lacked documentation of medication set up ahead of time for methadone to include documentation of the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration and the name of the person completing medication setup. This information was found in the facility's narcotic record, but not in R5's individual record.

R6
R6's diagnoses included, but were not limited to, Alzheimer's disease, anemia, anxiety, esophageal reflux, hyperlipidemia, osteoarthritis and anxiety.

R6's Individualized Service Plan dated May 11, 2021, indicated the resident received medication management services.

R6's Medication Management Plan dated May 5, 2021, indicated the client's medications would be set up by a licensed nurse; controlled substances (medications) would be provided in limited quantities after licensed nurse set up, and stored separately from other medications. R5's plan indicated staff will document the administration of medications through the electronic medication administration record (eMAR). The plan did not include information about documentation of medication set up ahead of time for later

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01770	Continued From page 8 administration. R6's prescriber's orders dated September 16, 2021, included but were not limited to, acetaminophen (indicated for pain); buspirone and lorazepam (indicated for anxiety); ferrous sulfate (iron supplement); gabapentin (indicated for nerve pain); omeprazole (indicated for esophageal reflux); paroxetine (antidepressant); and three vitamin supplements. On September 30, 2021, at approximately 10:15 a.m. R6 was observed seated in a wheel chair, appropriately dressed and groomed. R6 sported a moustache and was dozing off in front of the TV. On September 30, 2021, at approximately 10:44 a.m. ULP-C showed the surveyor how R6's medications were set up and explained how she administered the resident's medications. ULP-C pulled out a medication cassette (also called pill organizer/pill container/pill box, a multi-compartment compliance aid for storing scheduled doses of medications, typically with lidded compartments in a row for each day of the week and frequently with multiple rows, corresponding to different times of day when medication is to be administered) stored in the medication cart. R6's cassette had three of four rows filled with pills; the top row compartments were labeled "morn" (morning) and each day of the week; the second row's were labeled "Noon" and each week day; the third row was empty; and the fourth row's compartments were labeled "Bed" (bed time)" and each week day. In addition, ULP-C retrieved a laminated card, which listed R6's cassette medications, including the name of the medicine, dose, number of pills, and description of the pills, along with the time to	01770		

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01770	Continued From page 9 administer the medications. ULP-C explained she used the card to match up the medications she pulled out of the cassette for the specified day and time, and compared them to the electronic MAR, and "this is how I do my checks before I give the medications." ULP-C was asked if there was documentation of who set the medications up, as well as the dates of medication setup, the name of the medication, quantity of dose, times to be administered and route of administration. ULP-C said the only thing she saw documented in the eMAR was who gave the medications after administration. R6's MARs from August and September 2021, lacked documentation of medication set up ahead of time for methadone to include documentation of the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration and the name of the person completing medication setup. On September 30, 2021, at approximately 11:45 a.m. licensed practical nurse (LPN)-A reviewed and discussed the facility's system to set up of medications ahead of time and realized they did not meet guidelines. LPN-A acknowledged when medications were set up for R5 and R6, they did not document the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration and the name of the person completing medication setup. Although medication set up was documented in the narcotic record, and contained all required content, for R5's methadone, LPN-A acknowledged this information was the way the facility tracked the narcotics, but the documentation "was not part of [R5's] record."	01770		

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01770	Continued From page 10 Registered nurse (RN)-B stated the company's other sites printed out a MAR for the month and documented medication setup on the days when set up took place. RN-C stated "well be coming up with a plan to see what is best for the staff to do at this site." The licensee's Medication Administration System - Dosage Box Set Up policy dated August 23, 2021, indicated the nurse would transcribe medication prescription onto the medication profile. The profile would include: medication name and strength; dosage of medication';day and time of administration; route of administration; drug classification and special precautions; and any specific instructions for administering the medication to the client. Further, when the nurse has completed setting up the medications in the dosage box, the nurse will document each individual medication that has been set up on the MAR/EMAR (medication administration record) or other section of resident's legal medical record. No further information was provided. TIME PERIOD FOR CORRECTION: 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	01940		

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01940	Continued From page 11 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 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 a treatment management plan to include all required content for one of three residents (R4) reviewed for treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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	01940		

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	20394	A. BUILDING: _____ B. WING _____	09/30/2021

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01940	Continued From page 12 situation has occurred only occasionally). The findings include: R4's diagnoses included, but were not limited to left-side hemiplegia and hemiparesis, vascular dementia, atrial fibrillation, type 2 diabetes, hypertension and congestive heart failure. On September 29, 2021, at approximately 7:48 a.m. unlicensed personnel (ULP)-E and ULP-D provided morning cares for R4, which also included grooming and dressing. ULP-D was observed to apply TED (thrombo embolic deterrent) hose (used to improve circulation to prevent blood clot) bilaterally on R4's legs. At approximately 8:15 a.m., ULP-D stated she dressed R4, and verified she applied R4's TED hose for the resident. R4's Individualized Service Plan effective September 29, 2021, indicated the resident received assistance of two staff for dressing in both the mornings and evenings. R4's Treatment/Therapy Management Plan dated September 20, 2021, indicated staff were to ensure the resident's CPAP (continuous positive airway pressure- used as a sleeping aid for sleep apnea) was on at bed time; however, the plan lacked any mention R4 had a treatment of TED hose. R4's prescriber's orders dated January 5, 2021, directed: patient to wear compression sleeve and knee high compression hose; wear schedule on in a.m. and off in p.m., applied by facility staff; may leave off if patient declines wearing them.	01940		

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01940	Continued From page 13 R4's Treatment/Therapy Management Plan lacked the following content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatment or therapy administration; - identification of the treatment or therapy that will be delegated to unlicensed personnel; - procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and - any resident-specific requirements relating to documenting 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 30, 2021, at approximately 11:39 a.m. licensed practical nurse (LPN)-A stated they had "no treatment plan" for R4's TED hose. LPN-A also verified, there was no documentation of staff completing that task for R4 and added she would "put the documentation" on the MAR (medication administration record). LPN-A verified there was a current order for the application of the compression socks, but this was missed. The licensee's Development of the Individualized Therapy/Treatment Plan policy revised July 28, 2021, indicated for each resident receiving management of ordered or prescribed treatments, the registered nurse must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided tot he resident. The policy indicated the resident treatment record must	01940		

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01940	Continued From page 14 contain at least: - statement of the type of services that will be provided; - documentation of specific instruction relating tot he treatment or therapy administration; - tasks that will be delegated to unlicensed personnel; and - any resident-specific requirements relating to documentation of treatment and therapy received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document treatment administration for one of three residents (R4) reviewed with treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01960		

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01960	Continued From page 15 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: R4's diagnoses included, but were not limited to, left-side hemiplegia and hemiparesis, vascular dementia, atrial fibrillation, type 2 diabetes, hypertension and congestive heart failure. On September 29, 2021, at approximately 7:48 a.m. unlicensed personnel (ULP)-E and ULP-D provided morning cares for R4, which included grooming and dressing. ULP-D was observed to apply TED (thrombo embolic deterrent) hose (compression socks used to improve circulation to prevent blood clot) bilaterally on R4's legs. At approximately 8:15 a.m. ULP-D stated she dressed R4, and verified she applied R4's TED hose for the resident. R4's Individualized Service Plan effective September 29, 2021, indicated the resident received assistance of two staff for dressing in both the mornings and evenings. R4's Treatment/Therapy Management Plan dated September 20, 2021, indicated staff were to ensure the resident's CPAP (continuous positive air pressure - a sleeping aid used for sleep apnea) was on at bed time; however, the plan lacked any mention R4 had the treatment of TED hose.	01960		

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01960	Continued From page 16 R4's prescriber's orders dated January 5, 2021, directed: patient to wear compression sleeve and knee high compression hose; wear schedule on in a.m. and off in p.m., applied by facility staff; may leave off if patient declines wearing them. R4's August and September 2021, treatment administration records lacked documentation of application of compression stockings for R4. On September 30, 2021, at approximately 11:39 a.m. licensed practical nurse (LPN)-A stated they had "no treatment plan" for R4's compression socks. LPN-A also verified, there was no documentation of staff completing that task for R4 and added she would "put the documentation" on the MAR (medication administration record). LPN-A verified there was a current order for the application of the compression socks, but this was missed. The licensee's Documentation of medication, Treatment and Therapy Management Services policy revised July 28, 2021, indicated the RN will document the services the client will receive on the client's individualized treatment/therapy plan and the client's medication/treatment record or MAR/TAR. The policy also directed staff will document each task immediately, or as soon as reasonably possible, after that task has been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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02040	Continued From page 17 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide hazard vulnerability assessment, as required by MN Statute 144G.81 Subd.1 (a). 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 28, 2021, between 9:43 a.m. and 10:15 a.m. an interview and record review was conducted with the executive director (ED). The facility did not have a record of or a policy on a hazard vulnerability assessment for the property. ED verified they did not have a hazard vulnerability assessment, but had taken steps to	02040		

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02040	Continued From page 18 identify certain individual hazards in the past. These individual hazards had been documented at the time of risk with mitigation measures, but then were abandoned when the risk was no longer a factor. No further information was received. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		