DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 29, 2022

Administrator
Kingsway Retirement Living
815 West Main Street
Belle Plaine, MN 56011

RE: Project Number(s) SL30661015

Dear Administrator:

On April 11, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 27, 2022, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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: 507-344-2730 Fax: 651-215-9697

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

March 9, 2022

Administrator
Kingsway Retirement Living
815 West Main Street
Belle Plaine, MN 56011

RE: Initial License Number 403331
Health Facility Identification Number (HFID) 30661
Project Number(s) SL30661015

Dear Administrator:

On February 10, 2022, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the initial evaluation completed September 27, 2021. The February 10, 2022 follow-up evaluation determined your agency had corrected some, but not all, of the state licensing orders. **Based on the improvements, the conditions on the license were removed effective February 15, 2022; however, non-compliance remains.**

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on 09272021, found not corrected at the time of the February 10, 2022, follow-up evaluation and subject to a penalty assessment are as follows:

0510-Infection Control Program-144g.41 Subd. 3 - $500.00
0900-Contract Required-144g.50 Subdivision 1
1460-Orientation Of Staff And Supervisors-144g.63 Subdivision 1
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1770-Documentation Of Medication Setup-144g.71 Subd. 9
1890-Prescription Drugs-144g.71 Subd. 20

The details of the violations noted at the time of this follow-up evaluation completed on February 10, 2022 (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.

Also, at the time of this follow-up evaluation completed on February 10, 2022, we identified the following violation(s):

0650-Employee Records-144g.42 Subd. 8

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint evaluations, and as otherwise needed. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date. 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

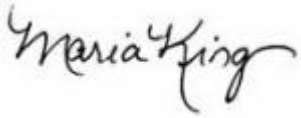
Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact Jodi Johnson, Supervisor, at jodi.johnson@state.mn.us, or 507-696-2437.

Sincerely,



Maria King, RN
Interim Division Director

Minnesota Department of Health
Health Regulation Division

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	R 02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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 these correction orders are 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 # SL30661015-1 On February 8, 2022 through February 10, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 27, 2021. At the time of the survey, there were 61 residents; 35 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 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.	
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	{0 510}		

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{0 510}	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control, and for current conditions of COVID-19. This had the 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 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: The licensee failed to ensure staff wore appropriate eye protection when in direct contact with residents.	{0 510}		

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{0 510}	Continued From page 2 On February 8, 2022, at 1:16 p.m. life enrichment coordinator (LEC)-K was observed sitting with five residents around the television, and holding hands with a resident. LEC-K was wearing a surgical face mask but no eye protection. At this time, LEC-K confirmed she was not wearing any eye protection and stated, "I went out for a walk and forgot to put it back on, thanks for reminding me." LEC-K then obtained and applied goggles. On February 9, 2022, at approximately 9:10 a.m. unlicensed personnel (ULP)-L was observed pushing a resident in a wheelchair to the dining room table. Though ULP-L was wearing goggles, the face mask was worn below ULP-L's nose. On February 9, 2022, at 9:30 a.m. ULP-L assisted R29 with toileting and morning cares. ULP-L's face mask was observed below her nose while providing the direct care assistance. On February 9, 2022, at approximately 11:30 a.m. licensed assisted living director (LALD)-J stated goggles and face masks are required for staff during care needs and/or any prolonged times with a resident within six feet. LALD-J further indicated the licensee followed the Centers for Disease Control and Prevention (CDC) guidelines. The licensee's COVID-19 policy dated December 2021, indicated the licensee continues to follow current and evolving information on COVID-19 from the CDC. The Centers for Disease Control and Prevention (CDC) guidance titled COVID-19 Integrated County View dated February 9, 2022, indicated Scott County, Minnesota was considered high level of community transmission of COVID-19.	{0 510}		

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{0 510}	Continued From page 3 The Minnesota Department of Health (MDH) guidance titled, COVID-19 Personal Protective Equipment and Source Control Grids for Congregate Care Settings By Community Transmission Level dated December 7, 2021, indicated when community transmission level is high, health care workers, including employees, contractors, and volunteers, working with residents without suspected or confirmed SARS-CoV-2 (COVID-19) infection, need to wear a facemask and eye protection. The guidance defines a facemask as "a surgical, medical procedure, dental, or isolation mask that is FDA (Food and Drug Administration)-cleared, authorized by an FDA EUA (emergency use agreement), or offered or distributed as described in an FDA enforcement policy" and defines eye protection as goggles or a face shield that covers the front and sides of the face. No further information was provided.	{0 510}		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of	0 650		

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0 650	Continued From page 4 staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of two employees (registered nurse (RN)-D, RN-M) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-D RN-D started providing services to the licensee	0 650		

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0 650	Continued From page 5 via a contracted supplemental staffing agency on September 21, 2021, and lacked an employee record with the required content to include: - records of orientation; and - TB history and symptom screening. RN-D's employee record contained a T-SPOT TB test dated March 2, 2020, but it did not contain a TB history and symptom screening. RN-M RN-D started providing services to the licensee via a contracted supplemental staffing agency on September 21, 2021, and lacked an employee record with the required content to include: -TB history and symptom screening. RN-M's employee record contained a QuantiFERON-TB Gold lab test dated February 26, 2021, but it did not contain a TB history and symptom screening. On February 10, 2022, at approximately 11:00 a.m. registered nurse (RN)-E confirmed both RN-D and RN-M's employee files lacked a TB history and symptom screening. The licensee's 4.05 Employee Records policy dated September 13, 2021, noted the licensee would keep an employee record of all training and in-service education for all paid employees. Employee records for each person will include: - verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings; and - verification of completed orientation	0 650		

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0 650	Continued From page 6 No further information was provided.	0 650		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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	{0 810}		

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{0 810}	Continued From page 7 by: No further action required.	{0 810}		
{0 900} SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility,	{0 900}		

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{0 900}	Continued From page 8 a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to develop and execute an assisted living written contract to include the required content for five of five residents (R1, R2, R3, R4, R26) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1, R2, R3, R4, and R26 all began receiving assisted living services on August 1, 2021. R1 R1's Service Plan dated September 23, 2021, indicated the resident received services which included medication administration. R1's record lacked an assisted living contract as required. R2 R2's Service Plan dated October 29, 2019, indicated the resident received services which included medication administration and weekly bathing assistance.	{0 900}		

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{0 900}	Continued From page 9 R2's record lacked an assisted living contract as required. R3 R3's Addendum Service Plan dated January 30, 2022, indicated the resident received services including medication administration, bathing, dressing, and grooming assistance. R3's record lacked an assisted living contract as required. R4 R4's Addendum Service Plan dated January 27, 2022, indicated the resident received services including medication administration, bathing, dressing, grooming, transfer, and continence assistance. R4's record lacked an assisted living contract as required. R26 R26's Addendum Service Plan dated December 9, 2021, indicated the resident received services including medication administration, bathing, grooming, dressing, transfers, and continence assistance. R26's record lacked an assisted living contract as required. During the entrance conference on February 8, 2022, at approximately 10:15 a.m. licensed assisted living director (LALD)-J stated the contract had been developed, a letter sent out informing residents of the new contract and was in the process of getting the new contract signed by all residents.	{0 900}		

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{0 900}	Continued From page 10 On February 8, 2022, at 2:31 p.m. LALD-J stated only two residents had signed the newly developed contract. LALD-J verified not all current residents had received or signed the contract, including the above-named residents. The licensee's 1.05 Signing an Assisted Living Contract policy dated October 21, 2021, indicated when a prospective resident is ready to sign a lease and move in, a signed assisted living contract will be completed between the resident and/or resident representative and the facility. No further information was provided.	{0 900}		
{01460} SS=E	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure orientation to assisted living licensing requirements and regulations was provided for four of four employees (registered nurse (RN)-M, RN-D, Life Enrichment Coordinator LEC-K, unlicensed personnel ULP-L) with records reviewed.	{01460}		

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	30661	A. BUILDING: _____ B. WING _____	R 02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
{01460}	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on February 8, 2022, at approximately 10:15 a.m. licensed assisted living director (LALD)-J stated an orientation checklist and additional education had been added to the orientation process to ensure compliance. RN-M, RN-D, LEC-K, and ULP-L's employee records lacked evidence the employees completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. RN-M started providing services for the licensee via a contracted supplemental staffing agency on September 21, 2021. LEC-K started providing services for the licensee on November 7, 2000. On February 8, 2022, at 1:16 p.m., LEC-K was observed sitting with five residents around the television holding hands. ULP-L started providing services for the licensee on August 31, 2021.	{01460}		

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{01460}	Continued From page 12 On February 9, 2022, at 8:29 a.m. ULP-L was observed to administer medications to R29. RN-D started providing services for the licensee via a contracted supplemental staffing agency on September 21, 2021. RN-D's employee record lacked evidence the employee completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. On February 10, 2022, at 1:43 p.m. LALD-J stated only new employees have had the required orientation, and indicated anyone hired prior to September 27, 2021, (previous survey date) would not have completed the orientation to assisted living facility licensing requirements and regulations as required. LALD-J further added the course had been reset today for all staff to complete The facility's 5.01 Orientation of Staff and Supervisors and Content policy dated September 13, 2021, noted all staff providing and supervising direct services would complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided.	{01460}		
{01760} SS=E	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	{01760}		

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{01760}	Continued From page 13 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 interview and record review, the licensee failed to ensure medication was administered as prescribed for four of five residents (R4, R29, R18, 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 pattern scope (when more than a limited number of resident's 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: R4 R4's Addendum Service Plan dated January 27, 2022, indicated the resident received services which included medication administration. R4's prescriber orders dated January 4, 2022, included the following medications: DuoNeb (for wheezing and shortness of breath)	{01760}		

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{01760}	Continued From page 14 0.5 milligram (mg)/3 milliliters (ml) - 2.5 (3) mg/3 ml solution inhalation daily; Tylenol (pain reliever) 975 milligrams (mg) by mouth three times a day; divalproex sodium (anticonvulsant) 250 mg capsule delayed release sprinkle three times a day; med pass supplement: Ensure twice daily in between meals due to weight loss; give with AM and bedtime (HS) med pass. A review of R4's electronic health record (EHR) dated January 10, 2022, through February 10, 2022, indicated R4's record lacked documentation of administered medications for the following dates: DuoNeb - AM dose on February 9, 2022 Tylenol - HS dose on February 8, 2022 divalproex sodium - HS dose on February 8, 2022 med pass supplement - AM dose on January 20, 2022, and February 1, 2022 - PM dose February 8, 2022 R29 R29's Addendum Service Plan dated February 9, 2022, indicated the resident received services which included medication administration. R29's Individualized Treatment Plan dated October 26, 2021, indicated the resident received weight monitoring. R29's prescriber orders dated February 8, 2022, included: metoprolol succinate (for high blood pressure) 150 mg by mouth daily; hold if systolic blood pressure is less than 100.	{01760}		

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{01760}	Continued From page 15 check weight daily. Review of R29's EHR dated February 1, 2022, through February 9, 2022, indicated R29's record lacked documentation of administered medication/treatment for the following dates: metoprolol succinate -February 3, 2022 check weight daily -February 2, 2022, and February 5, 2022 R18 R18's Service Plan dated October 22, 2021, indicated the resident received services which included medication administration. R18's prescriber orders dated January 25, 2022, included: Biofreeze 0.2%-3.5% gel apply to affected areas left (L) and right (R) hip twice a day. Review of R18's EHR dated February 1, 2022, through February 9, 2022, indicated R18's record lacked documentation of administered medication for the following date: Biofreeze -AM February 5, 2022 -PM February 7, 2022 R3 R3's Addendum Service Plan dated January 30, 2022, indicated the resident received services which included medication administration. R3's prescriber orders dated December 22, 2021, included the following medications: Nystatin 100000 unit/gram powder (antifungal) apply to affected areas redness in groin twice a day.	{01760}		

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{01760}	Continued From page 16 Review of R3's EHR dated February 1,2022, through February 9, 2022, indicated R3's record lacked documentation of administered medication for the following date: Nystatin powder -AM dose on February 6, 2022 On February 10, 2022, at 10:30 a.m. registered nurse (RN)-A confirmed the above-named residents' MARs lacked documentation of administration for the above listed dates. RN-A indicated without a signature in the residents' EHR, there was no proof the medications were administered, nor was there alternative documentation of why it wouldn't have been given. The licensee's 7.22 Medication & Treatment Record Documentation & Refusal policy dated September 1, 2021, indicated the signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy would be documented in the residents' records after providing medication assistance or administration. The policy also included any refusal of medication would be documented on the [medication administration record] MAR. No further information was provided.	{01760}		
{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.	{01770}		

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{01770}	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for three of three residents (R22, R23, R24) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R22's electronic medication administration record (EMAR) dated January 2022, lacked documentation of the medication setup to include the name of the medication, quantity of dose, times to be administered, and route of administration. R23's EMAR dated January 2022, lacked documentation of the medication setup to include the name of the medication, quantity of dose, times to be administered, and route of administration. R24's EMAR dated January 2022, lacked documentation of the medication setup to include the name of the medication, quantity of dose, times to be administered, and route of administration.	{01770}		

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{01770}	Continued From page 18 On February 8, 2022, at approximately 2:00 p.m. licensed assisted living director (LALD)-J confirmed R22, R23, and R24's record did not include the above information. The licensee's 7.09 Medication Management-Dosage Box Setup Policy dated October 22, 2021, indicated a licensed nurse would setup medications weekly to include medication name, quantity of dose, times to be administered, and the route of administration. No further information was provided.	{01770}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly for one of four residents (R16) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	{01890}		

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{01890}	Continued From page 19 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R16's prescriber orders dated January 25, 2022, included an order for Senna S (laxative) 8.6 milligrams (mg)-50 mg one (1) tablet by mouth every other day for constipation, and one tablet by mouth twice a day as needed for constipation. R16's medication administration record (MAR) dated February 2022, included the same orders for Senna S 8.6 mg-50 mg one tablet by mouth every other day for constipation, and one tablet by mouth twice a day as needed for constipation. On February 9, 2022, at approximately 1:50 p.m. R16's Senna S medication card and MAR was observed with unlicensed personnel (ULP)-L. The surveyor noted the label did not match the order. The label had R16's name on it but read "Senna S 8.6 mg-50 mg take two tabs by mouth every other day, and as needed one-two tabs daily." ULP-L verified the current label did not match the order on the MAR, and indicated a nurse needed to be notified. On February 9, 2022, at 2:00 p.m. registered nurse (RN)-A verified the current order did not match the label and confirmed all medication labels should match the prescriber order. The licensee's policy was requested, but not provided. No further information provided.	{01890}		

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{02040}	Continued From page 20	{02040}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment 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: No further action required.	{02040}		

Electronically Delivered

October 26, 2021

Administrator
Kingsway Retirement Living
815 West Main Street
Belle Plaine, MN 56011

RE: Project Number(s) SL30661015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 27, 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, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0700 - 144g.43 Subdivision 1 - Resident Record - $3,000.00
St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00

The total amount you are assessed is $6,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. 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

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, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. 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.

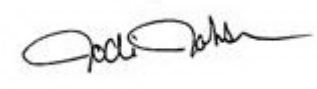
INFORMAL CONFERENCE
At any time, the Commissioner of Health is authorized by Minn. Stat. § 144G.20, subd. 20 to hold an informal conference to exchange information, clarify issues, or resolve issues.

The Minnesota Department of Health staff would like to schedule a conference call with Kingsway Retirement Living. Please contact Jodi Johnson at 507-696-2437, on or before Friday, October 29, 2021, to schedule the conference call. 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.

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
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P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

HHH

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KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL#30661015 On September 21, 2021, through September 27, 2021, the Minnesota Department of Health conducted a survey ath the above provider, and the following correction orders are issued. At the time of the survey, there were 74 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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	0 250		

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	30661	A. BUILDING: _____ B. WING _____	09/27/2021

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0 250	Continued From page 1	0 250		

provisional license, refuse to grant a license as a 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;
(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 section 144.057 or 245A.04;
(12) fails to timely pay any fines assessed by the

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0 250	Continued From page 2 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 facility failed to show they had met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations, had developed and implemented current policies and procedures as required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 September 21, 2021, at approximately 10:45 a.m., the licensed assisted living director (LALD) confirmed she was responsible for and participated in the day-to-day operations. The LALD stated to be familiar with the Assisted Living with Dementia licensing rules.	0 250		

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0 250	Continued From page 3 The facility had attested they read and understood the Assisted Living with Dementia Care licensing statues and rules upon application. The facility failed to implement the following required policies and procedures: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Center for Disease Control and Prevention standards; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. Refer to licensing order at Statute 144G.42, Subd. 6 and 626.557, Subd. 3. The facility failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R5) with record reviewed. Refer to licensing order at Statute 144G.63,	0 250		

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0 250	Continued From page 4 Subd. 1. The facility failed to ensure one of two employees (RN-D) received orientation to assisted living facility licensing requirements and regulations with records reviewed. Refer to licensing order at Statute 144G.70, Subd. 2. The facility failed to ensure the registered nurse (RN) conducted ongoing client monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for eight of eight residents (R1, R2, R3, R4, R7, R8, R9 and R19.) Refer to licensing order at Statute 144G.90, Subd. 1. The facility failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement was received for eight of eight residents (R1, R2, R3, R4, R7, R8, R9 and R19). Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. Refer to licensing order at Statute 144G.42, Subd. 9. 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) which included a completed health history and symptom screening for one of two employees (RN-D). Refer to licensing order at Statute 144G.71, Subd. 1. The licensee failed to ensure the security and accountability of controlled	0 250		

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0 250	Continued From page 5 substances being managed for two of two medication carts located in the secured memory care unit. Refer to licensing order at Statute 144G.71, Subd. 3. The facility failed to ensure the RN completed annual medication reassessments for four of seven residents (R1, R2, R7 and R8). Refer to licensing order at Statute 144G.71, Subd. 8. The facility failed to ensure medication was administered as prescribed for two of four residents (R4, R3) with records reviewed. In addition, the facility failed to ensure medication orders were transcribed to the medication administration record (MAR) accurately for one of one resident (R18). Refer to licensing order at Statute 144G.71, Subd. 9. The facility failed to ensure documentation of medication setup included all the required content for two of two residents (R1, R2). Refer to licensing order at Statute 144G.71, Subd. 14. The facility failed to renew prescriptions at least every 12 months for one of four residents (R4). Refer to licensing order at Statute 144G.71, Subd. 20. The facility failed to ensure medications were labeled correctly for one of four residents (R16). Refer to licensing order at Statute 144G.71, Subd. 22. The facility failed to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to	0 250		

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0 250	Continued From page 6 whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R5). Refer to licensing order at Statute 144G.72, Subd. 3. The facility failed to include in the service plan a written statement of the treatment or therapy services that will be provided to the resident for one of two residents (R3) for compression socks. Refer to licensing order at Statute 144G.72, Subd. 5. The facility failed to ensure documentation that treatments were completed as instructed for one of two residents (R3) for compression socks. Refer to licensing order at Statute 144G.72, Subd. 6. The facility failed to ensure there were current treatment orders which contained all the required information for one of two residents (R3) for compression socks. Thirty-four (34) correction orders were issued, which indicated the facility 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		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to	0 430		

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0 430	Continued From page 7 prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a copy of the uniform checklist disclosure of services with the required content for eight of eight residents (R1, R2, R4, R3, R7, R8, R9, R19) with records reviewed. 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: R1, R2, R4, R3, R7, R8, R9, R19's record lacked	0 430		

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0 430	Continued From page 8 a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract R1 On September 22, 2021, at approximately 8:17 a.m. unlicensed personnel (ULP)-A was observed to administer R1's morning medications. R1's service plan dated September 23, 2021, indicated the resident received services which included medication administration. R2 R2's service plan dated September 28, 2020, indicated the resident received services which included medication administration and weekly bathing assistance. On September 22, 2021, at approximately 11:30 a.m. ULP-A was observed to administer R2's 11:30 a.m. medications. R4 R4's service plan dated September 28, 2020, indicated the resident received services which included medication administration, transfer assist and mobility escorts.	0 430		

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0 430	Continued From page 9 On September 22, 2021, at approximately 9:45 a.m. registered nurse (RN)-D was observed to administer R4 a nebulizer treatment. R3 R3's service plan dated July 3, 2019, indicated the resident received services which included medication administration, therapeutic ambulation, transfer and mobility escorts. R7 R7's service plan dated August 12, 2021, indicated the resident received services which included medication administration, transferring, toileting and dressing and grooming. R8 R8's, undated and unsigned, service plan indicated the resident received services which included medication administration, bathing, activities of daily living (ADLs) and transfer assistance. R9 R9's service plan dated August 30, 2021, indicated the resident received services which included medication administration. R19 R19's service plan dated July 30, 2021, indicated the resident received services which included medication administration, and bathing.	0 430		

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0 430	Continued From page 10 On September 23, 2021, at approximately 4:12 p.m. RN-E stated all residents should have received a copy of the uniform disclosure of assisted living services and amenities (UDALSA) after August 1, 2021. RN-E confirmed all residents receiving services under the facility's license had not received a copy of the UDALSA as required. The facility's 1.04 UDALSA policy dated September 13, 2021, noted the facility would provide a UDALSA to prospective residents prior to signing an Assisted Living contract. The facility would obtain written acknowledgement from the resident or resident's representative that they provided the UDALSA or document the reason why an acknowledgement was not obtained. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
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	0 470		

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0 470	Continued From page 11 and to emergency, life safety, and disaster 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, implemented, and evaluated for appropriateness of staffing levels as required, potentially affecting all of the 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 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: The facility's staff plan dated October 2020, indicated the number of full time employees it	0 470		

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0 470	Continued From page 12 required; however, it did not identify if the plan was for a day, month or year. The staff plan did not include how the plan was developed or implemented to ensure sufficient staffing was met for all residents' needs. On September 23, 2021, at 4:09 p.m. registered nurse (RN)-E stated a staffing plan and evaluation should be completed per the new state regulation. On September 23, 2021, at 5:33 p.m. the licensed assisted living director (LALD) confirmed the only documentation for a staffing plan was the document that was provided. A staff planning policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision.	0 510		

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0 510	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control, and for current conditions of COVID-19. This had the 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 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: HANDWASHING The licensee failed to ensure staff completed hand hygiene appropriately while providing direct cares for residents. On September 22, 2021, at approximately 7:48 a.m. unlicensed personnel (ULP)-A was observed to enter R21's room to administer morning medications. Upon entry, ULP-A grabbed a paper envelope out of a rolling cart, knocked and entered the resident's room. ULP-A administered the medications enclosed in the envelope to R21 and exited the room. About 30 minutes later, ULP-A entered R1's room to administer morning mediations from a medication caddie located in R1's room. ULP-A poured the medications from the medication caddie into R1's hands and proceeded to give an eye drop into each eye,	0 510		

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0 510	Continued From page 14 without washing their hands. ULP-A did not complete hand hygiene between the two resident encounters or tasks. On September 22, 2021, at approximately 8:35 a.m. the surveyor questioned ULP-A when hand hygiene should occur. ULP-A stated "I should have" washed hands with soap and water or used an alcohol-based rub between tasks and residents. ULP-A's training records indicated she was trained on infection control techniques/handwashing on September 1, 2020, and February 15, 2021. The licensee's Handwashing policy dated September 13, 2021, indicated handwashing was to be performed by all employees, as necessary, between tasks and procedures to prevent cross-contamination. EQUIPMENT CLEANING The licensee failed to disinfect medical equipment between resident use. On September 22, 2021, at approximately 8:30 a.m. ULP-A was observed to take R1's temperature, and oxygen saturation level (SpO2). After obtaining the temperature and SpO2, ULP-A placed the thermometer and pulse oximeter in a bag and documented the results. On September 22, 2021, at approximately 8:35 a.m. the surveyor asked ULP-A about cleaning medical equipment between residents. ULP-A stated she should have, but had forgotten. The Minnesota Department of Health (MDH)	0 510		

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	30661	A. BUILDING: _____ B. WING _____	09/27/2021

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0 510	Continued From page 15 guidance, titled COVID-19 Toolkit, Information for Long Term Care Facilities dated March 8, 2021, indicated to disinfect surfaces with an EPA-registered disinfectant with a label indicating effectiveness against human Coronavirus or emerging viral pathogens. High-touch surfaces include but are not limited to: door handles, railings, light switches, remotes, phones, call buttons, medical equipment (lifts, thermometers, pulse oximeter), etc. ULP-A's training record indicated COVID-19 vaccines and FAQ (frequent asked questions) training was completed on June 5, 2021. The licensee's Cleaning of Shared Medical Equipment policy dated September 13, 2021, indicated all equipment must be cleaned immediately if visibly soiled, and immediately after use on residents with contact precautions regardless of cleaning schedule. Clean non-critical medical equipment surfaces with a mild detergent followed by cleaning with a disinfectant. CLIENT MONITORING FOR COVID-19 The facility failed to screen and monitor for COVID-19 symptoms at least daily for R4 and R3. MDH guidance, titled COVID-19 Toolkit, Information for Long Term Care Facilities dated March 8, 2021, indicated all residents should be actively screened for fever and symptoms consistent with COVID-19 at least daily. If a pulse oximeter was available, daily screening was recommended. Chart all clinical measurements and symptoms for each resident. R4 and R3's records lacked evidence of daily COVID-19 screening and monitoring to include	0 510		

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0 510	Continued From page 16 SpO2, temperature, and symptom screening. R4 R4's records dated September 2021, lacked documentation of temperature and SpO2, and documentation the resident had been screened for COVID-19 symptoms. R3 R3's physician orders dated November 18, 2020, indicated to check temperature, respirations, and SpO2 twice a day, and to assess for shortness of breath, chills or cough - if symptoms were present, notify the nurse. R3's Medication Administration Record (MAR) for September 2021, indicated the resident was only screened six (6) out of 17 opportunities. On September 24, 2021, at approximately 9:40 a.m. RN-A confirmed they had a pulse oximeter available for use. RN-A verified R4 and R3 were lacking daily monitoring of temperature, oxygen saturation levels and symptom screening daily for COVID-19 as required. The facility's COVID-19 policy, dated May 5, 2020, identified active monitoring and surveillance of residents or tenants is important to early detection and recognition of potential outbreaks of all infectious illnesses in long-term care settings. The policy recommended: -at minimum daily respiratory assessments including SPO2 and lung sounds -at minimum two times a day temp checks with full VS (vital signs) as appropriate. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 510		

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0 510	Continued From page 17 days	0 510		
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R5) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's diagnoses included, but were not limited to, dementia (memory loss), diabetes type II (condition that affects the way the body processes blood sugar), and hypertension (high	0 620		

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0 620	Continued From page 18 blood pressure). A Resident Fall Documentation Form dated August 29, 2021, at 5:00 p.m. identified R5 was found on the bathroom floor laying on the right side, yelling and complaining of shoulder pain. The form further indicated the nurse was notified. A Professional Portable X-Ray report for R5 was completed on August 30, 2021, at 3:34 a.m. for pain due to the fall. The findings included an acute right femoral neck fracture (broken hip). R5's Discharge Summary dated September 21, 2021, identified R5 was discharged to the hospital on August 30, 2021, where R5 later expired. On September 23, 2021, at approximately 4:12 p.m. registered nurse (RN)-E stated a vulnerable adult (VA) report to MAARC should be made when a resident's care plan was not followed or anytime there were significant injuries like broken bones. RN-E further confirmed R5's right hip fracture should have been reported. The facility's 2.44 Vulnerable Adult Maltreatment-Prevention & Reporting dated September 13, 2021, indicated the facility educates clients, family members, and staff (mandated reporters) about how to report suspected maltreatment internally and to MAARC. Staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect) or who has knowledge that a resident has sustained a physical injury which is not reasonable explained will: a. take immediate action to protect or keep safe, the resident affected b. call 911 if emergency assistance is needed c. Contact the Clinical Nurse Supervisor if	0 620		

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0 620	Continued From page 19 medical attention is needed d. Contact the Assisted Living Director e. The Assisted Living Director or Clinical Nurse Supervisor will determine how to best protect other resident from similar maltreatment in the immediate future f. If the Assisted Living Director or Clinical Nurse Supervisor confirms the suspicion of maltreatment, they will contact MAARC. Such report must be made no later than 24 hours after the maltreatment was first suspected. g. Reports can be made to MAARC via the online portal No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 640		

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0 640	Continued From page 20 review, the facility failed to support protection and safety by not posting information and phone numbers for the 911 emergency number in common areas and near telephones provided by the assisted living facility. 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: The licensee failed to: - post 911 in commons area and near telephones provided by the assisted living facility. On September 15, 2021, at approximately 10:30 a.m. during a facility tour, the licensed assisted living director (LALD) showed surveyors a communication board where information regarding Vulnerable Adult laws/abuse prevention procedure was located, and a community phone. The posted information lacked the 911 emergency number. The facility's Vulnerable Adult Maltreatment-Prevention & Reporting policy dated September 13, 2021, indicated the facility will post information for reporting suspected crime and maltreatment. The facility will support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult	0 640		

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0 640	Continued From page 21 maltreatment by posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 650 SS=A	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with	0 650		

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0 650	Continued From page 22 the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the employee record contained the required content for one of two employees (registered nurse (RN)-D) with records reviewed. 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 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: During the entrance conference on September 21, 2021, at approximately 10:45 a.m. the licensed assisted living director (LALD), RN-B and RN-F stated the facility used supplemental staffing agencies to meet their staffing needs for licensed personnel. RN-D started providing services to the licensee via a contracted supplemental staffing agency on September 21, 2021, and lacked an employee record with the required content to include: - records of orientation; - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - verification that required health screenings under subdivision 9 have taken place and the	0 650		

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0 650	Continued From page 23 dates of those screenings On September 22, 2021, at approximately 7:39 a.m. RN-D stated yesterday was her first day working at the facility and had not received any orientation to the assisted living. On September 22, 2021, at approximately 8:04 a.m. RN-D was observed to provide direct care services for R16, which included administering scheduled morning medications. On September 27, 2021, at approximately 11:55 a.m. the LALD confirmed the employee record lacked the above required content. The facility's 4.05 Employee Records policy dated September 13, 2021, noted the facility would keep an employee record for all paid employees. Employee records for each person will include: - a current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any. - verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings; and - verification of completed orientation No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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	0 660		

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0 660	Continued From page 24 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility 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) which included documentation of a completed health history and symptom screening for one of two employees (registered nurse (RN)-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 21, 2021, at approximately 10:45 a.m. with the licensed assisted living director (LALD), RN-B	0 660		

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0 660	Continued From page 25 and RN-F, a request was made to review the facility TB risk assessment. The TB risk assessment dated September 2019, indicated the licensee was a 'low risk.' RN-D started providing services to the licensee via a contracted supplemental staffing agency on September 21, 2021. RN-D's employee record lacked evidence of the following: - TB history and symptom screening On September 27, 2021, at approximately 11:55 a.m. the LALD brought in a negative chest x-ray dated March 2, 2020, for RN-D; however, no further documentation was provided. The facility's 8.16 Tuberculosis Screening policy dated September 13, 2021, noted staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCW's (health care workers). 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in	0 660		

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0 660	Continued From page 26 each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." 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;	0 680		

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0 680	Continued From page 27 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 record review the facility failed to have a written emergency preparedness plan with all the required content. This had the 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 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 September 21, 2021, at approximately 10:45 a.m. a request was made to view the licensee's emergency preparedness plan. The facility's plan consisted of a number of	0 680		

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0 680	Continued From page 28 documents and policies contained in a red three-ringed binder titled "Emergency Preparedness Manual". The book included a risk assessment, a communication plan, various policies/procedures, and after action reviews. The licensee's plan lacked the following required content: - description of the population served by licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations. - development of policies/procedures to address: - shelter in place On September 27, 2021, at approximately 9:35 a.m. the licensed assisted living director (LALD) indicated she was familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). The LALD acknowledged their current emergency preparedness plan was not complete. The facility's 9.02 Disaster Planning and Emergency Preparedness policy dated September 13, 2021, noted the facility would have in place a general emergency preparedness plan, that was in alignment with facility's requirement to also comply with CMS Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 700	Continued From page 29	0 700		
0 700 SS=G	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to protect one of one resident record (R7) against tampering with record review. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: R7's diagnoses included hypothyroidism (under active thyroid), insomnia, and pain. R7's service plan dated August 12, 2021, indicated the resident received services which included medication administration, transferring, toileting, dressing and grooming. R7's prescriber orders were signed on September 10, 2021, which included an order for oxycodone	0 700		

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0 700	Continued From page 30 (narcotic pain reliever) 5 milligrams (mg) daily. An email received on September 22, 2021, at 12:31 p.m. from a Minnesota Department of Health (MDH) triage specialist identified a nurse practitioner (NP) was at the facility and found documents with her name forged. On September 22, 2021, at 1:43 p.m. the NP stated she looked through R7's record and noticed the signature on the prescriber orders was not hers. The NP reported this to the administrator and to the pharmacy. On September 23, 2021, at 4:09 p.m. the licensed assisted living director (LALD) verified the NP reported the forged physician orders to the facility and they were investigating the issue. The LALD stated staff were questioned and denied forging the physician orders. The LALD stated she had not yet gone through other residents' records to see if this was a pattern. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal	0 730		

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0 730	Continued From page 31 representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status.	0 730		

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0 730	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation of services had been provided as identified in the service plan for six of six residents (R2, R3, R7, R8, R9 and R19) with records reviewed. In addition, the facility failed to complete a discharge summary for one of one resident (R5) with discharge record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: On September 21, 2021, during the entrance conference, registered nurse (RN)-B and RN-E indicated the service plans and assessments were on paper and located in the residents' records. RN-B and RN-E did not know how unlicensed personnel (ULP) documented services provided to residents. R2 R2's record lacked evidence to indicate bathing assistance had been provided as identified on the resident's service plan. R2's service plan dated September 28, 2020, indicated the resident would be provided, but not limited to, bathing assistance weekly. R2's undated 90-day assessment indicated the resident required assistance of one with bathing,	0 730		

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0 730	Continued From page 33 and there were no changes to the services the resident received. R2's record lacked documentation to indicate bathing assistance had been provided, as identified on the resident's service plan. R3 R3's record lacked documentation to indicate AM/PM cares including dressing, hygiene/grooming assistance and continence assistance had been provided as identified on the resident's service plan. R3's service plan dated July 3, 2019, indicated the resident would be provided, but not limited to, the following services: AM/PM cares including dressing, hygiene/grooming assistance, and continence assistance with assist of one to the bathroom AM/PM, after meals and as needed throughout the day and night. R3's undated 90 day assessment, indicated the resident required assistance with dressing, grooming, bathing, and transferring, and there were no changes to the services the client received. R3's record lacked documentation to indicate dressing, hygiene/grooming and continence assistance had been provided as identified on the resident's service plan. R7 R7's service plan dated August 12, 2021, indicated the resident received services which included medication administration, transferring, toileting and dressing and grooming.	0 730		

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0 730	Continued From page 34 R8 R8's undated and unsigned service plan, indicated the resident received services which included medication administration, bathing, activities of daily living (ADL) and transfer assistance. R9 R9's service plan dated August 30, 2021, indicated the resident received services which included medication administration. R19 R19's service plan dated July 30, 2021, indicated the resident received services which included medication administration, and bathing. On September 22, 2021, at 1:30 p.m. ULP-D stated agency staff did not have access to the resident's electronic record to document services provided, and there was no other way for staff to document. On September 23, 2021, at 12:03 p.m. ULP-E stated she has provided direct cares for the past month, and did not have access to the electronic record to document services provided. On September 23, 2021, at 2:30 p.m. documentation of services provided for R7, R8, R9, and R19 were requested, but not provided. On September 23, 2021, at approximately 4:10 p.m. RN-E stated documentation of services provided by staff should be in the resident's record.	0 730		

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0 730	Continued From page 35 Discharge Summary R5's diagnoses included, but were not limited to, dementia (memory loss), diabetes type II (condition that affects the way the body processes blood sugar), and hypertension (high blood pressure). R5 discharged from the facility on August 30, 2021. R5's record lacked a discharge summary; however, when requested by the surveyor, a discharge summary was provided and dated September 21, 2021. On September 23, 2021, at 4:12 p.m. RN-E confirmed the discharge summary had not been completed until it was requested by the surveyor. RN-E further indicated the discharge summary should be done as soon as possible. The licensee's policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
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	0 810		

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0 810	Continued From page 36 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 interview and record review the facility failed to provide evidence that an employee and resident training plan compliant, with MN Statute 144G.45, was in place. In addition, the facility failed to provide evidence that an evacuation drill policy, schedule or log compliant with MN Statute 144G.45 was in place. 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	0 810		

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0 810	Continued From page 37 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: On September 22, 2021, at approximately 11:30 a.m. while reviewing records, the facility provided evidence that new employees were trained upon hire; however, there was no evidence of an employee training plan to be held twice per year as required. In addition, there was no evidence of a plan for annual training for residents, or a plan for required evacuation drills as required. On September 22, 2021, at approximately 11:50 a.m. the licensed assisted living director (LALD) confirmed the facility had not yet developed or implemented the required employee training program and schedule for fire safety and evacuation plans. In addition, the facility had not yet developed or implemented the required resident training program for fire safety and evacuation plans, or evacuation drills as required. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or	0 900		

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0 900	Continued From page 38 provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to develop and execute an assisted living	0 900		

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0 900	Continued From page 39 written contract to include all required content for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1, R2, R3, and R4 all began receiving assisted living services on August 1, 2021. R1 On September 22, 2021, at approximately 8:17 a.m. unlicensed personnel (ULP)-A was observed to administer R1's morning medications. R1's Service Plan dated September 23, 2021, indicated the resident received services which included medication administration. R1's record lacked an assisted living contract as required.. R2 R2's Service Plan dated September 28, 2020, indicated the resident received services which included medication administration and weekly bathing assistance. On September 22, 2021, at approximately 11:30 a.m. ULP-A was observed to administer R2's	0 900		

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0 900	Continued From page 40 medications. R2's record lacked an assisted living contract as required. On September 24, 2021, at approximately 11:59 a.m. registered nurse (RN)-E confirmed R1 and R2's resident file did not include an assisted living contract as required. RN-E stated a contract should be developed or executed for the facility's current residents or upon move in as required. R3 R3's Service Plan dated July 3, 2019, indicated the resident received services including, but not limited to, assistance with grooming and hygiene, bathing, assistance with toileting, transfers, ambulation, and medication management. On September 21, 2021, at 4:00 p.m. R3 stated he received assistance with toileting, bathing, dressing and undressing, medications, and meals. R3's record contained a Resident Agreement, undated and unsigned, which was 52 days after the resident began receiving services under the assisted living facility license. On September 24, 2021, at approximately 12:34 p.m. the licensed assisted living director (LALD) stated R3 did not like to sign papers, and further verified there was no documentation that R3 had refused to sign the contract. R4 R4's Service Plan dated September 28, 2020, indicated the resident received assisted living services including, but not limited to, cue and	0 900		

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0 900	Continued From page 41 direct to all specific destinations including meals and activities, and medication management. R4's record contained a Resident Agreement, dated August 20, 2021, which was 20 days after the resident began receiving services under the assisted living facility license. On September 24, 2021, at approximately 11:58 a.m. RN-E verified R4's contract had been signed late, and should have been in place by August 1, 2021. A policy was requested, but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01330 SS=D	144G.60 Subd. 4 Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a	01330		

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01330	Continued From page 42 training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of three unlicensed personnel (ULP-D and ULP-E) completed training and competency evaluations in all required training topics with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D ULP-D had a hire date of August 1, 2021, as an employee that would not provide direct cares; however, ULP-D had provided direct cares and administered medications throughout the month of September 2021. On September 21, 2021, at 2:34 p.m. ULP-D stated she provided direct cares and administered medications during the month of September 2021. ULP-D stated she worked throughout the entire building and assisted as needed. In addition, ULP-D stated she had not received training or competencies regarding direct care or medication administration. ULP-D's record lacked documentation the employee had successfully completed training	01330		

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01330	Continued From page 43 and demonstrated competency in all of the required areas. ULP-E ULP-E had a hire date of August 1, 2021, as an employee that would not provide direct cares; however, ULP-E provided direct cares throughout September 2021. ULP-E's record lacked documentation the employee had successfully completed training and demonstrated competency in all of the required areas. On September 21, 2021, at 1:46 p.m. ULP-E stated during the past month she provided direct cares due to short staffing, and provided cares throughout the entire building wherever she was needed. ULP-E stated she had not received training or competencies for direct cares. On September 22, 2021, at 2:30 p.m. registered nurse (RN)-B verified ULP-D and ULP-E's record lacked evidence of completed training and competency testing in all required training topics. On September 23, 2021, at 4:09 p.m. RN-E stated training and competency testing should be completed before providing care or delegated nursing tasks, such as passing medications. On September 23, 2021, at 5:33 p.m. the licensed assisted living director (LALD) stated staff should be trained before providing direct care or administering medications, but the facility was in a difficult and challenging position related to staff shortage. The facility's Competency Training Evaluations	01330		

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01330	Continued From page 44 policy dated September 13, 2021, indicated required training topics in 144G.61, subdivision 2 should be completed prior to the delegation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure orientation to assisted living licensing requirements and regulations was provided for one of two employees (registered nurse (RN)-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01460		

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01460	Continued From page 45 situation has occurred only occasionally). The findings include: During the entrance conference on September 21, 2021, at approximately 10:45 a.m. the licensed assisted living director (LALD), RN-B and RN-F stated the facility used supplemental staffing agencies to meet their staffing needs for licensed personnel. RN-D started providing services for the licensee via a contracted supplemental staffing agency on September 21, 2021. On September 22, 2021, at approximately 7:39 a.m. RN-D stated yesterday was her first day working at the facility, and she had not received any orientation to assisted living facility licensing requirements and regulations. On September 22, 2021, at approximately 8:04 a.m. RN-D was observed to provide direct care services for R16, including administering R16's scheduled morning medications. RN-D's employee record lacked evidence the employee completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. On September 27, 2021, at approximately 11:55 a.m. the LALD verified RN-D had not completed the orientation to assisted living facility licensing requirements and regulations as required. The facility's 5.01 Orientation of Staff and Supervisors and Content policy dated September 13, 2021, noted all staff providing and supervising direct services would complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents.	01460		

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01460	Continued From page 46 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01480 SS=E	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for four of four employees (unlicensed personnel (ULP)-E, ULP-B, ULP-D and registered nurse (RN)-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: ULP-E ULP-E had a hire date of August 1, 2021, as an employee that would not provide direct care.	01480		

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01480	Continued From page 47 On September 21, 2021, at 1:46 p.m. ULP-E stated during the past month, she had provided direct care throughout the entire building wherever she was needed due to short staffing. ULP-E further stated she had not received orientation of resident needs and she just "winged it." ULP-E stated the facility did not put her on the master schedule, but she was expected to provide cares. ULP-B ULP-B started providing direct care for the licensee via a contracted supplemental staffing agency on September 20, 2021. ULP-B's record lacked documentation she had been oriented to individual residents before providing direct cares. On September 22, 2021, at 7:39 a.m. ULP-B stated she had asked for help to identify the residents from another staff member, and give direction on cares. ULP-D ULP-D had a hire date of August 1, 2021, as an employee that would not provide direct care. On September 23, 2021, at 2:34 p.m. ULP-D stated she had passed medications and provided direct care throughout the month of September 2021, but did not receive orientation to individual residents before providing direct cares. RN-D RN-D started providing direct care via a contracted supplemental staffing agency on September 21, 2021. RN-D's record lacked documentation she had been oriented to individual residents before providing direct cares. On September 22, 2021, at 7:39 a.m. RN-D stated she had asked for help to identify the	01480		

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01480	Continued From page 48 residents from another staff member for their medications, but didn't know the residents' routines or care needs. On September 23, 2021, at 3:10 p.m. RN-A stated resident orientation was completed when staff were trained. RN-A stated new staff were mentored by another staff person. On September 23, 2021, at 4:09 p.m. RN-E stated new staff should be oriented to residents before providing direct care. The facilities Orientation of Staff and Supervisors & Content policy dated September 13, 2021, indicated staff providing assisted living services must be orientated specifically to each individual resident and services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01480		
01620 SS=F	144G.70 Subd. 2 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	01620		

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01620	Continued From page 49 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 observation, interview, and record review, the facility failed to ensure the registered nurse (RN) conducted ongoing client monitoring and reassessments, not to exceed 90 calendar days from the last assessment for eight of eight residents (R1, R2, R3, R4, R7, R8, R9, and R19) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1 R1's diagnoses included, but were not limited to Parkinson's disease (A disorder of the central	01620		

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01620	Continued From page 50 nervous system that affects movement, often including tremors) and glaucoma (a condition of increased pressure within the eyeball, causing gradual loss of sight.) R1's service plan dated September 23, 2021, indicated the resident received services including medication administration. On September 22, 2021, at approximately 8:17 a.m. unlicensed personnel (ULP)-A was observed to administer R1's morning medications. R1's last two assessments were requested. A comprehensive home care assessment dated March 9, 2021, and another undated 90-day assessment was provided. R2 R2's diagnoses included, but were not limited to diabetes and heart failure (A chronic condition in which the heart doesn't pump blood as well as it should.) R2's service plan dated September 28, 2020, indicated the resident received services including medication administration and weekly bathing assistance. On September 22, 2021, at approximately 11:30 a.m. ULP-A was observed to administer R2's 11:30 a.m. medications. R2's last two assessments were requested. A resident assessment dated March 27, 2015, and another undated 90-day assessment was provided. R3	01620		

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01620	Continued From page 51 R3's diagnoses included, but were not limited to, anemia (lack of red blood cells), anxiety, bilateral osteoarthritis of knees (form of arthritis), chronic tremor (shaking movement in one or more parts of the body), edema (swelling caused by excess fluid trapped in tissue), and hypertension (high blood pressure). R3's service plan dated July 3, 2019, indicated the resident received services including medication administration, therapeutic ambulation, transfer and mobility escorts. R3's last two assessments were requested. A 14-day assessment dated July 17, 2019, and another 90 day undated assessment was provided. R4 R4's diagnoses included, but were not limited to dementia (memory disorder), asthma (a condition affecting the lungs causing breathlessness, chest tightness, and coughing) and anxiety (feeling of uneasiness, fear and worry). R4's service plan dated September 28, 2020, indicated the resident received services including medication administration, transfer assist and mobility escorts. R4's last two assessments were requested, a 90 day assessment dated June 3, 2019, and another undated 90 day assessment was provided. On September 23, 2021, at 4:12 p.m. RN-E stated when assessments are completed, they should include the nurse's signature and date. RN-E verified all of the 90 day reassessments were lacking the dates of completion.	01620		

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01620	Continued From page 52 R7 R7's diagnoses included hypothyroidism (under active thyroid), insomnia, and pain. R7's service plan dated August 12, 2021, indicated the resident received services including medication administration, transferring, toileting and dressing and grooming. R7's last two assessments were requested, but were not provided. R8 R8's diagnoses included seizure disorder, and traumatic brain injury and chronic pain. R8's undated and unsigned, service plan indicated the resident received services including medication administration, bathing, activities of daily living (ADL) and transfer assistance. R8's last two assessments were requested, but not provided. R9 R9's diagnoses included major depression, acute pain, and muscle spasms. R9's service plan dated August 30, 2021, indicated the resident received services including medication administration. R9's last two assessments were requested, but not provided. R19 R19's diagnoses included congestive heart failure	01620		

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01620	Continued From page 53 (CHF), tachycardia (high heart rate), pain, and anxiety. R19's service plan dated July 30, 2021, indicated the resident received services including medication administration, and bathing. R19's last two assessments were requested, but not provided. On September 23, 2021, at 4:09 p.m. RN-E stated assessments should be completed per regulation, and should be signed and dated when completed. The facility's Assessment Review & Monitoring policy dated September 13, 2021, indicated resident assessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be on as needed based on changes in the needs of resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640		

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01640	Continued From page 54 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of four resident (R4) service plans were revised to reflect the current services provided. In addition, the facility failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services provided for four of six residents (R7, R8, R9, and R19) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01640		

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01640	Continued From page 55 R4 R4's diagnoses included, but were not limited to dementia (memory disorder), asthma (a condition affecting the lungs causing breathlessness, chest tightness, and coughing) and anxiety (feeling of uneasiness, fear and worry). On September 21, 2021, at approximately 3:30 p.m. unlicensed personnel (ULP)-G stated R4 needed assistance with showering, dressing and grooming tasks. ULP-G further included R4 received assistance with toileting and incontinence cares. R4's service plan dated September 28, 2020, did not identify R4 received assistance with bathing, dressing/undressing, hygiene/grooming assistance or toileting assistance. On September 23, 2021, at 4:12 p.m. RN-E stated all service plans should be revised as needed with signatures, and RN-E would expect to see a copy in the chart. R7 R7's diagnoses included hypothyroidism (under active thyroid), insomnia, and pain. R7's service plan dated August 12, 2021, indicated the resident received services including medication administration, transferring, toileting and dressing and grooming. The service plan was signed by RN-A and indicated verbal consent was given, but it did not include a date, time, or who gave verbal consent. R8 R8's diagnoses included seizure disorder, and traumatic brain injury and chronic pain.	01640		

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01640	Continued From page 56 R8's undated and unsigned service plan, indicated the resident received services including medication administration, bathing, activities of daily living (ADL) and transfer assistance. The service plan was signed by RN-A and indicated verbal consent was given, but it did not include a date, time, or who gave verbal consent. R9 R9's diagnoses included major depression, acute pain, and muscle spasms. R9's service plan, dated August 30, 2021, indicated the resident received services including medication administration. The service plan was signed by RN-A and indicated verbal consent was given, but it did not include a date, time, or who gave verbal consent. R19 R19's diagnoses included congestive heart failure (CHF), tachycardia (high heart rate), pain, and anxiety. R19's service plan dated July 10, 2021, indicated the resident received services including medication administration, and bathing. The service plan was signed by RN-A and indicated verbal consent was given, but did not include a date, time, or who gave verbal consent. In addition, R19's September 2021, medication administration record (MAR) indicated R19 self-administered her medications. On September 23, 2021, at 4:09 p.m. RN-E stated when verbal consent is given it should include who gave verbal consent, date, and a plan to get the service plan signed.	01640		

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01640	Continued From page 57 The facility's Service Plan Modifications policy dated September 13, 2021, indicated when a resident receives assisted living services and a change(s) to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and	01690		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01690	Continued From page 58 designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the security and accountability of controlled substances for two of two medication carts located in the locked memory care unit. This had the potential to affect all residents and staff in the memory care unit. 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 September 21, 2021, at approximately 10:45 a.m. the licensed assisted living director (LALD), registered nurse (RN)-B and RN-F confirmed the facility provided medication management services. The facility lacked evidence of maintaining a	01690		

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	30661	A. BUILDING: _____ B. WING _____	09/27/2021

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KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

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01690	Continued From page 59 consistent security and accountability of controlled medications. On September 22, 2021, at 10:00 a.m. two medication carts in the locked memory care unit were reviewed with RN-D. In each locked medication cart, there was a second locked drawer containing the narcotic medications. On top of each medication cart was a bound narcotic record book. RN-D stated two staff counted the narcotic medications between each shift, but no signatures were documented from September 14, 2021, until September 22, 2021 (eight days) in medication cart #1. There was no count documented on September 15, 2021, or from September 16, 2021, until September 22, 2021 (6 days) in medication cart #2. In addition, the verified count of oxycodone (a schedule II controlled medication) for R22 did not match the actual amount in medication cart #1. R21's Individual Narcotic Record Administration Record identified there were six (6) oxycodone tablets; however, upon counting with the surveyor, there were only five (5) oxycodone tablets. RN-D was able to correct the discrepancy and identified when the medication was last signed out on September 19, 2021, the amount remaining column had not been updated to reflect the new count. RN-D corrected the count and initialed the change in narcotic book at this time. RN-D indicated staff had miscounted, and verified the error should have been caught during narcotic count. On September 23, 2021, at 4:12 p.m. RN-E stated narcotic counts should be done each change of shift, and any discrepancy should be reported immediately to the RN.	01690		

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01690	Continued From page 60 The facility's 7.11 Medication Storage policy dated September 13, 2021, indicated schedule II drugs will be counted at the beginning and end of every shift, with counts compared to schedule II medications ordered to be administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01710 SS=E	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 observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication reassessments for four of seven residents (R1, R2, R7 and R8) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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	01710		

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01710	Continued From page 61 found to be pervasive). The findings include: R1 R1's diagnoses included, but were not limited to, Parkinson's disease (A disorder of the central nervous system that affects movement, often including tremors) and glaucoma (a condition of increased pressure within the eyeball, causing gradual loss of sight.) On September 22, 2021, at approximately 8:17 a.m. unlicensed personnel (ULP)-A was observed to administer R1's morning medications. R1's service plan dated September 23, 2021, indicated the resident received services including medication administration. R1's record lacked documentation of an annual medication reassessment. The most recent medication assessment was dated March 9, 2020. R2 R2's diagnoses included, but were not limited to, diabetes and heart failure (A chronic condition in which the heart doesn't pump blood as well as it should). R2's service plan dated September 28, 2020, indicated the resident received services including medication administration and weekly bathing assistance. On September 22, 2021, at approximately 11:30 a.m. ULP-A was observed to administer R2's 11:30 a.m. medications.	01710		

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01710	Continued From page 62 R2's record lacked documentation of an annual medication reassessment. The most recent medication assessment was dated October 9, 2018. R7 R7's diagnoses included hypothyroidism (under active thyroid), insomnia, and pain. R7's service plan dated August 12, 2021, indicated the resident received services including medication administration, transferring, toileting and dressing and grooming. R7's last medication assessment was requested, but not provided. R8 R8's diagnoses included seizure disorder, and traumatic brain injury and chronic pain. R8's undated and unsigned service plan, indicated the resident received services including medication administration, bathing, activities of daily living (ADL) and transfer assistance. R8's last medication assessment was requested, but not provided. On September 23, 2021, at 4:39 p.m. RN-E confirmed the annual medication reassessment needed to be completed at least yearly and R1, R2, R7 or R8's medication assessments were not updated or current. A policy was requested, but not provided. No further information was provided.	01710		

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01710	Continued From page 63 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01710		
01740 SS=D	144G.71 Subd. 6 Administration of medication Medications may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of two unlicensed personnel (ULP-D) had been trained and competency tested prior to delegating administering medications. 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-D's hire date was August 1, 2021, as an employee that would not provide direct care. Upon review of the second and third floor residents' medication administration records (MAR), it was noted ULP-D had administered medications numerous times throughout the	01740		

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01740	Continued From page 64 month of September 2021, with the most recent being September 16, 2021. On September 21, 2021, at 2:34 p.m. ULP-D stated she provided direct care and administered medications during the month of September 2021. ULP-D stated she worked throughout the entire building and assisted as needed. ULP-D stated she had not received training regarding medication administration. On September 23, 2021, at 4:09 p.m. registered nurse (RN)-E stated training and competency testing should be completed before administering medications. On September 23, 2021, at 5:33 p.m. the licensed assisted living director (LALD) stated staff should be trained before providing direct care or passing medications, but the facility was in a difficult and challenging position related to staff shortage. The facility's Competency Training Evaluations policy dated September 13, 2021, indicated only ULP who are determined to be competent and posses the knowledge and skills consistent with the complexity of the tasks being delegated will be permitted to perform delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01740		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 65 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 facility failed to ensure medication was administered as prescribed for two of four residents (R4, R3) with records reviewed. In addition, the licensee failed to ensure medication orders were transcribed to the medication administration record (MAR) accurately for one of one resident (R18) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of resident's 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: MEDICATIONS NOT GIVEN AS PRESCRIBED R4	01760		

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01760	Continued From page 66 R4's diagnoses included, but were not limited to, dementia (memory disorder), asthma (a condition affecting the lungs causing breathlessness, chest tightness, and coughing) and anxiety (feeling of uneasiness, fear and worry). R4's service plan dated September 28, 2020, indicated the resident received services which included medication administration. R4's prescriber orders dated August 12, 2020, included the following medications: Seroquel (antipsychotic) 25 milligrams (mg) by mouth four times a day; Tylenol (non-narcotic pain reliever) 325 mg 3 tablets by mouth three times a day; divalproex sodium (anticonvulsant)125 mg 2 capsules by mouth three times a day; A review of the September 2021 medication administration record (MAR), indicated R4's medication record lacked documentation of administered medications for the following dates: Seroquel - PM and HS (hour of sleep) dose on September 15, 2021 Tylenol - Afternoon and HS dose on September 15, 2021 divalproex sodium -HS dose on September 15, 2021 R3 R3's diagnoses included, but were not limited to, anemia (lack of red blood cells), anxiety, bilateral osteoarthritis of knees (form of arthritis), chronic tremor (shaking movement in one or more parts of the body), edema (swelling caused by excess fluid trapped in tissue), and hypertension (high blood pressure).	01760		

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01760	Continued From page 67 R3's service plan dated July 3, 2019, indicated the resident received services which included medication administration. R3's prescriber orders dated November 18, 2020, included the following medications: Nystatin powder (antifungal) apply to affected areas in groin twice a day; clonazepam (antianxiety, antiepileptic) 1 mg by mouth three times a day; acetaminophen 500 mg 2 tablets by mouth three times a day; multiple vitamin-minerals (supplement) 1 capsule by mouth daily; A review of the September 2021, MAR indicated R3's medication record lacked documentation of administered medications for the following dates: Nystatin powder -AM dose on September 4, 7, 8, and 16, 2021 -2000 dose on September 16, 2021 clonazepam -1900 dose on September 6, 2021 acetaminophen -1900 dose on September 6, 2021 multiple vitamin-minerals -1900 dose on September 6, 2021 On September 24, 2021, at 2:32 p.m. registered nurse (RN)-A confirmed both R3 and R4's medication record lacked documentation of administration for the above listed dates. RN-A further verified without a signature there was no proof the medications were administered, nor was there alternative documentation of why it wouldn't have been given. The facility's 7.22 Medication & Treatment Record Documentation & Refusal policy dated September 1, 2021, indicated the signature and	01760		

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01760	Continued From page 68 title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy would be documented in the residents records after providing medication assistance or administration. The policy also included any refusal of medication would be documented on the MAR. TRANSCRIPTION ERROR R18's Physician Orders dated June 20, 2021, included, but was not limited to: cephalexin (antibiotic) 500 mg by mouth twice a day AM and PM x seven (7) days with the first date: March 8, 2021, for genitourinary infection. DC (discontinue) was written to the side of this order and signed by the physician. R18's MAR dated September 2021, included, but was not limited to: - cephalexin 500 mg by mouth twice a day AM and PM x 7 days. On September 22, 2021, at 8:30 a.m. RN-D was observed to prepare R18's morning medications. The MAR included an order for cephalexin as noted above. RN-D double checked that there were no more medications for the client, then stated it looked like an old order that should have been discontinued, and not on the current MAR. RN-D further stated she would need to look into this order as to why it was still on current MAR. On September 23, 2021, at 4:12 p.m. RN-E stated the order should have been transcribed into the MAR to include a start and end date, and it had not been transcribed as ordered.	01760		

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01760	Continued From page 69 The facility's 7.16 Medications & Treatment Orders- Implementing dated September 13, 2021, lacked instruction on transcribing orders. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	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 facility failed to ensure documentation of medication setup included all the required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01770		

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01770	Continued From page 70 During the entrance conference on September 21, 2021, at 11:10 a.m. registered nurse (RN)-B indicated medications were usually in bubble packs, but some residents had medications setup weekly by the nurse. R1 On September 22, 2021, at 7:48 a.m. R1's medications were observed in a seven-day dosage box in the assisted living medication cart. R1's record lacked documentation of the medication setup to include the name of the medication, quantity of dose, times to be administered, and the route of administration. This was verified with RN-A on September 24, 2021, at 10:18 a.m. R2 On September 22, 2021, at 8:17 a.m. R2's medications were observed in a seven-day dosage box located in the resident's apartment. R2's record lacked documentation of the medication setup to include the name of the medication, quantity of dose, times to be administered, and route of administration. This was verified with RN-A on September 24, 2021, at 10:18 a.m. A policy was requested, but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions	01830		

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01830	Continued From page 71 Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to renew prescriptions at least every 12 months for one of four residents (R4) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 record lacked an annual renewal of prescriber orders for medications. R4's diagnoses included, but were not limited to dementia (memory disorder), asthma (a condition affecting the lungs causing breathlessness, chest tightness, and coughing) and anxiety (feeling of uneasiness, fear and worry). R4's service plan dated September 28, 2020, indicated the resident received services which included medication administration. R4's Medication/Treatment/Therapy Management Plan dated September 23, 2020, indicated the resident received medication management	01830		

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01830	Continued From page 72 services which included medication administration. On September 22, 2021, at approximately 9:45 a.m. RN-D was observed to administer R4 a nebulizer treatment. R4's medication administration record (MAR), dated September 1 through September 21, 2021, included, but was not limited to the following medications: -Singulair (for asthma) 10 milligrams (mg) by mouth daily; -ipratropium-albuterol (for asthma) 0.5 mg/3 milliliters (ml) solution inhalation 3 ml daily; -divalproex sodium (for behaviors/mood stability) 250 mg delayed release sprinkle capsule by mouth three times a day; -Tylenol (for pain) 325 mg three (3) tablets by mouth 3 times a day; -Seroquel (for Wernicke's encephalopathy) 25 mg by mouth four (4) times per day; -albuterol sulfate 90 microgram (mcg) aerosol powder breath activated inhalation one (1) puff 3 times a day as needed (PRN) for wheezing; -acetaminophen 325 mg two (2) tablets by mouth every 4 hours PRN pain/fever not to exceed 4000 mg /24 hours; -guaifenesin 100 mg/5 ml 2 teaspoon by mouth every 4 hours PRN for cough; and -Milk of Magnesia 400 mg/5 ml 30 ml by mouth daily PRN followed by a full glass of water on day 3 without a bowel movement. R4's most current prescriber orders dated August 12, 2020, included all of the above medications; however, it was 40 days past the annual renewal date requirement. On September 24, 2021, at 12:24 p.m. the	01830		

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KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

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01830	Continued From page 73 licensed assisted living director (LALD) confirmed R4's prescriber orders had not been updated at least annually as required. The facility 7.18 Medication & Treatment Orders - Renewal policy dated September 13, 2021, indicated residents who receive medication management services will have a current physician prescribed medication order on record. The policy further included medication and treatment orders must be renewed at least every 12 months, or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
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 facility failed to ensure medications were labeled correctly for one of four residents (R16) 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	01890		

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01890	Continued From page 74 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: R16 R16's physician orders dated June 21, 2021, included an order for Senna S 8.6 milligrams (mg)-50 mg one (1) tablet by mouth every other day for constipation. R16's medication administration record (MAR) dated September 2021, included the same order for Senna S 8.6 mg-50 mg one tablet by mouth every other day for constipation. On September 22, 2021, at approximately 8:04 a.m. registered nurse (RN)-D prepared morning medications to be administered to R16. RN-D removed the medication card from the medication cart, and compared it to the MAR, hesitated, then punched a Senna S 8.6 mg-50 mg one tablet into the medication cup. The surveyor examined the medication card and noted the label did not match the order. The label had R16's name on it, but it read "Senna S 8.6 mg-50 mg take two tabs by mouth every other day, and as needed one-two tabs daily." When RN-D was questioned about the label not matching, unlicensed personnel (ULP)-F interjected and stated a direction change sticker should have been on the card to alert staff of different orders. ULP-F placed a direction label change sticker on the card at this time. On September 23, 2021, at approximately 4:12 p.m. RN-E confirmed all medication labels need to match the prescriber order.	01890		

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01890	Continued From page 75 The licensee's policy was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: seven (7) days.	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications	01910		

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01910	Continued From page 76 were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R5) with record review. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's record lacked documentation of medication disposition upon the resident's discharge from facility. R5 was discharged from the facility on August 30, 2021, to a hospital where she later expired. R5's diagnoses included, but not limited to, dementia (memory loss), diabetes type II (condition that affects the way the body processes blood sugar), and hypertension (high blood pressure). R5's Service Plan dated September 28, 2020, indicated the client received medication administration services daily. R5's physician orders were requested, but not provided. R5's medication administration record (MAR) dated August 2021, included but were not limited to, the following medications: one mild-moderate pain reliever, one mild-moderate pain patch, one	01910		

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01910	Continued From page 77 moderate-severe schedule II narcotic pain reliever, one anti-diabetic medication, one schedule IV anti-anxiety, two antidepressants, and one anticonvulsant. R5's Discharge Summary dated September 21, 2021, noted the resident had been discharged to a hospital on August 30, 2021, where she later expired. Some of the medications and their dosages were listed under reconciliation of medications; however, R5's record lacked evidence of the disposition of medications to include the prescription number, quantity, and the names of the staff and other individuals involved in the disposition. On September 23, 2021, at approximately 4:12 p.m. registered nurse (RN)-E verified R5's record did not include documentation of medication disposition as noted above. RN-E further verified she was unable to locate a medication destruction log for R5. The facility's 7.23 Medication Disposal policy dated September 13, 2021, noted upon disposition, the facility would document the following information in the clinical record: the name, strength, and prescription number of medications as applicable; quantity; to whom the medications were given; the date of disposition; and the names of staff (including a witness) and other individuals involved in the disposition. A copy of the destruction record will be kept on file at the facility for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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01940	Continued From page 78	01940		
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 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 facility failed to include in the service plan a written statement of the treatment or	01940		

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01940	Continued From page 79	01940		

therapy services that will be provided to one of two residents (R3) for compression socks with records reviewed.
This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).
The findings include:
R3's Service Plan dated July 3, 2019, did not reflect the current treatments the resident was receiving. The service plan indicated the resident received treatments daily, which included a therapeutic ambulation task to walk resident with transfer belt and walker the length of hallway, or as much as tolerated.

R3's diagnoses included, but were not limited to, anemia (lack of red blood cells), anxiety, bilateral osteoarthritis of knees (form of arthritis), chronic tremor (shaking movement in one or more parts of the body), edema (swelling caused by excess fluid trapped in tissue), and hypertension (high blood pressure).

On September 23, 2021, at 6:41 p.m. R3 was observed to be wearing black compression stockings. When interviewed at this time, R3 stated the staff put them on in the morning and removed them each evening. The resident indicated the stockings "can be tough to get on sometimes."

On September 24, 2021, at 10:11 a.m. registered nurse (RN)-A confirmed R3 wore compression stockings that were applied by staff, and stated

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01940	Continued From page 80 compression stockings should be identified on the service plan. RN-A verified R3's service plan did not identify this treatment. A Treatment and Therapy Management Plan policy was requested, but not provided. No further information is available. TIME PERIOD FOR CORRECTION: Twenty-One (21) 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 facility failed to ensure documentation that treatments were completed as instructed for one of two residents (R3) with compression socks 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	01960		

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01960	Continued From page 81 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's record lacked documentation treatments were performed as indicated on the resident's Medication and Treatment Management Plan. R3's diagnoses included, but were not limited to, anemia (lack of red blood cells), anxiety, bilateral osteoarthritis of knees (form of arthritis), chronic tremor (shaking movement in one or more parts of the body), edema (swelling caused by excess fluid trapped in tissue), and hypertension (high blood pressure). R3's Medication/Treatment/Therapy Management Plan dated September 25, 2020, indicated the resident received services including compression garments; stockings on in AM, and off at HS (hour of sleep). R3's record lacked evidence of a written prescriber order for the compression stockings. R3's record lacked documentation to indicate compression stockings had been provided as identified on the resident's treatment plan. On September 23, 2021, at 6:41 p.m. R3 was observed to be wearing black compression stockings. When interviewed at this time, R3 stated the staff put them on and removed them each evening. The resident indicated the stockings "can be tough to get on sometimes." On September 24, 2021, at approximately 10:11	01960		

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01960	Continued From page 82 a.m. registered nurse (RN)-A stated R3's record should have documentation the compression stockings were applied and removed by staff. RN-A confirmed this was lacking in R3's record. The facility's Medication & Treatment Record - Documentation & Refusal policy dated September 1, 2021, indicated documentation of treatments will be completed by the person who preformed the task immediately after the treatment was completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure there were current treatment orders which contained all the required information for one of two residents (R3) for compression socks with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01970		

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01970	Continued From page 83 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: On September 23, 2021, at 6:41 p.m. R3 was observed to be wearing black compression stockings. When interviewed at this time, R3 stated the staff put them on in the morning and removed them each evening. The resident indicated the stockings "can be tough to get on sometimes." R3's diagnoses included, but were not limited to, anemia (lack of red blood cells), anxiety, bilateral osteoarthritis of knees (form of arthritis), chronic tremor (shaking movement in one or more parts of the body), edema (swelling caused by excess fluid trapped in tissue), and hypertension (high blood pressure). R3's Medication/Treatment/Therapy Management Plan dated September 25, 2020, indicated the resident had services being provided including compression garments; stockings on in AM, and off at HS (hour of sleep). R3's medical record lacked evidence of a prescriber order for the compression stockings. On September 24, 2021, at approximately 10:11 a.m. registered nurse (RN)-A verified R3's record lacked a prescriber order for the compression stockings. RN-A further verified if staff were applying compression stockings, a prescriber order was required.	01970		

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01970	Continued From page 84 The facility's 7.17 Medication & Treatment Orders-Receiving policy dated September 1, 2021, identified all orders for medication and treatments must be dated and signed by the prescriber, and must be current and consistent with the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment 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 the proper documentation that a hazard vulnerability or safety risk assessment had been performed on and around the property. This has the potential to affect all dementia care residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02040		

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02040	Continued From page 85 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: On September 22, 2021, at approximately 11:30 a.m. while reviewing records, the facility failed to provide evidence of a complete hazard vulnerability assessment as required. During an interview on September 22, 2021, at approximately 11:50 a.m. the licensed assisted living director (LALD) confirmed the facility had not yet developed the required hazard vulnerability assessment. The hazards indicated must be assessed and mitigated to protect the residents from harm. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of	02070		

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02070	Continued From page 86 residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure an awake person was physically present in a secured unit 24 hours a day, seven days a week whom were responsible for responding to requests of residents for assistance in a secured area. This resulted in an immediate correction order on September 23, 2021, at approximately 4:00 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility held an assisted living with dementia care license and was licensed for a bed capacity of 100 residents, with a current census of 74 residents. The facility did not ensure staff were physically present in a secured unit at all times. The staff schedule from September 8, 2021, to October 2, 2021, indicated one AL (assisted living) float 6:00 a.m. - 2:00 p.m., and one for independent living staff 6:00 a.m. - 2:00 p.m.; one AL float 2:00 p.m. - 10:00 p.m., and one	02070		

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	30661	A. BUILDING: _____ B. WING _____	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

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02070	Continued From page 87 independent living staff 4:00 p.m. - 10:00 p.m.; and one assisted living staff 10:00 p.m. - 6:00 a.m. On September 21, 2021, at approximately 12:18 p.m. during the initial tour of the facility with the licensed assisted living director (LALD), it was observed the facility consisted of a secured area, separate from the secured memory care unit, which was located on the third floor. There was a key pad to enter a code to be able to open the door to leave the secured area. The secured area had 10 total apartments, with eight (8) current residents. On September 23, 2021, at approximately 9:32 a.m. the LALD stated the secured third floor was used to "age in place," and verified it was secured for residents that wander. The LALD further stated there were no designated staff for the 3rd floor area, and there was one staff person shared between 2nd and 3rd floors. On September 23, 2021, at approximately 10:00 a.m. R3 stated he had a discussion with the LALD about a concern with the lock on the door, stating he was not fast enough to push the buttons and get the door to open. He further stated he can leave whenever he wanted too, but it was very difficult to get through the door. On September 23, 2021, at approximately 10:35 a.m. R6 stated concern of not being able to get out in case of an emergency, and the door was too heavy for residents to open. In addition, R6 reported staff were working on other floors, and R6 has had to wait 15 minutes in the past for staff to answer the pendant call to leave. On September 23, 2021, at approximately 10:59	02070		

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02070	Continued From page 88 a.m. unlicensed personnel (ULP)-D confirmed she has worked as needed shifts in the past month, and the regular staffing pattern was one ULP covered the second and third floors of the assisted living during the day and evening shifts, and one staff to cover overnight shift to all of the assisted living residents. ULP-D stated if another ULP needed assistance with a resident in a different area, the ULP would leave their assigned work area unattended to go and assist the ULP. On September 23, 2021, at approximately 11:04 a.m. registered nurse (RN)-C confirmed she was the only scheduled staff for the assisted living float that day, and she was covering floors two and three. Per the facility's letter to families dated July 20, 2021, "the secured area is a new safety measure and will ensure safety and security of the residents, as well as foster the Aging in Place model. The secured area is like 'Sophie Suites Neighborhood,' the third-floor safety measures will allow for controlled access points to and from the third-floor residents, staff, and guests. The new safety measure will continue to allow the current residents who reside in that area to age in place as their care needs change, continuing to promote freedom to move freely within the building as they were previously. For those who don't need to be accompanied, they will have the freedom to come and go from the third level. Residents will be assisted by staff upon request if they wish to leave third floor." A policy was requested, but not provided. On September 23, 2021, at approximately 8:00 p.m. the immediacy was removed as confirmed by onsite observations by the surveyors, and	02070		

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02070	Continued From page 89 document review/phone conversation between the LALD and the evaluation supervisor on September 23, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02070		
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 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	02170		

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02170	Continued From page 90 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 facility failed to conduct an individualized written activity evaluation that addressed all six provisions, and failed to write an individual activity plan for one of one resident (R4) who resided in the secured memory care unit with record review. 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 facility had a current assisted living with dementia care license. R4's diagnoses included, but were not limited to dementia (memory disorder), asthma (a condition affecting the lungs causing breathlessness, chest tightness, and coughing) and anxiety (feeling of uneasiness, fear and worry). R4's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the	02170		

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02170	Continued From page 91 following: - 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 On September 27, 2021, at approximately 3:54 p.m. the licensed assisted living director (LALD) stated she had a call out to the therapeutic recreation employee, but she did not know where the assessment was, or if it was completed for R4 as required. The facility's 1.34 Activity Programming policy provided dated September 13, 2021, did not address an individualized activity plan or evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also	02240		

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02240	Continued From page 92 contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided	02240		

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02240	Continued From page 93 and a written acknowledgement received for eight of eight residents (R1, R2, R3, R4, R7, R8, R9, and R19) with records reviewed. 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: R1 R1 began receiving assisted living services on August 1, 2021. The resident's record lacked evidence of the current Minnesota Home Care Bill of Rights (May 16, 2021) and a written acknowledgement it was received. R1's record was noted to have a signed Minnesota Home Care Bill of Rights dated March 3, 2020. R2 R2 began receiving assisted living services on August 1, 2021. The resident's record lacked evidence of the current Minnesota Home Care Bill of Rights (May 16, 2021) and a written acknowledgement it was received. R2's record was noted to have a signed Minnesota Home Care Bill of Rights dated October 29, 2019. R3 R3 began receiving assisted living services on August 1, 2021. The resident's record lacked evidence of the current Minnesota Home Care Bill of Rights (May 16, 2021) and a written acknowledgement it was received. R3's record was noted to have a signed Minnesota Home Care Bill of Rights dated August 1, 2019. R4	02240		

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02240	Continued From page 94 R4 began receiving assisted living services on August 1, 2021. R4's record contained the most current Minnesota Home Care Bill of Rights dated May 16, 2021; however, no written acknowledgement or signature of receipt was included. R7 R7's service plan dated August 12, 2021, indicated the resident received services which included medication administration, transferring, toileting and dressing and grooming. R7's record lacked evidence of the current Minnesota Home Care Bill of Rights (May 16, 2021) and a written acknowledgement it was received.. R8 R8's undated and unsigned service plan indicated the resident received services which included medication administration, bathing, activities of daily living (ADLs) and transfer assistance. R8's record lacked evidence of the current Minnesota Home Care Bill of Rights (May 16, 2021) and a written acknowledgement it was received. R9 R9's service plan, dated August 30, 2021, indicated the resident received services which included medication administration. R9's record lacked evidence of the current Minnesota Home Care Bill of Rights (May 16, 2021) and a written acknowledgement it was received. R19 R19's service plan dated July 30, 2021, indicated	02240		

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02240	Continued From page 95 the resident received services which included medication administration, and bathing. R19's record lacked evidence of the current Minnesota Home Care Bill of Rights (May 16, 2021) and a written acknowledgement it was received. On September 23, 2021, at 4:12 p.m. registered nurse (RN)-E stated all residents should have written receipt of receiving the bill of rights in their chart, and further verified none of the residents had it. The facility's 2.05 Bill of Rights policy dated September 13, 2021, indicated the facility must obtain written acknowledgment of the resident's receipt of the the BOR (Bill of Rights) or shall document why an acknowledgment cannot be obtained. Acknowledgment of BOR receipt will be retained in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the	03000		

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03000	Continued From page 96 individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.	03000		

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03000	Continued From page 97 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's diagnoses included, but were not limited to, dementia (memory loss), diabetes type II (condition that affects the way the body processes blood sugar), and hypertension (high blood pressure). A Resident Fall Documentation Form dated August 29, 2021, at 5:00 p.m. identified R5 was found on the bathroom floor, laying on the right side, yelling and complaining of shoulder pain. The form indicated the nurse was notified. A Professional Portable X-Ray report for R5 was completed on August 30, 2021, at 3:34 a.m. for pain due to the fall. The findings included an acute right femoral neck fracture (broken hip). R5's Discharge Summary dated September 21, 2021, identified R5 was discharged to the hospital on August 30, 2021, where she later expired. On September 23, 2021, at approximately 4:12	03000		

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03000	Continued From page 98 p.m. registered nurse (RN)-E stated a vulnerable adult (VA) report to MAARC should be made when a resident's care plan was not followed, or anytime there are significant injuries like broken bones. RN-E further confirmed R5's right hip fracture should have been reported. The facility's 2.44 Vulnerable Adult Maltreatment-Prevention & Reporting dated September 13, 2021, indicated the facility educates residents, family members, and staff (mandated reporters) about how to report suspected maltreatment internally and to MAARC. Staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect) or who has knowledge that a resident has sustained a physical injury which is not reasonable explained will: a. take immediate action to protect or keep safe, the resident affected b. call 911 if emergency assistance is needed c. Contact the Clinical Nurse Supervisor if medical attention is needed d. Contact the Assisted Living Director e. The Assisted Living Director or Clinical Nurse Supervisor will determine how to best protect other resident from similar maltreatment in the immediate future f. If the Assisted Living Director or Clinical Nurse Supervisor confirms the suspicion of maltreatment, they will contact MAARC. Such report must be made no later than 24 hours after the maltreatment was first suspected. g. Reports can be made to MAARC via the online portal No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

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

Type: Full
Date: *09/21/21*
Time: 12:30:31
Report: 8075211214

Food and Beverage Establishment Inspection Report

Location:
Kingsway Retirement Living
815 West Main Street
Belle Plaine, MN56011
Scott County, 70

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

License Categories:

Expires on: 12/31/21

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonium: = 200ppm at Degrees Fahrenheit
Location: warewashing sink wall dispenser
Violation Issued: No

Wash Temp: = at 150 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Rinse Temp: = at 182 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Utensil Surface Temp: = at 163 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 164 Degrees Fahrenheit - Location: hot holding unit - chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 180 Degrees Fahrenheit - Location: hot holding unit - soup
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: cooler - key lime pie
Violation Issued: No

Type: Full
Date: *09/21/21*
Time: 12:30:31
Report: 8075211214
Kingsway Retirement Living

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: cooler - hard boiled egg
Violation Issued: No

Process/Item: Cold Holding
Temperature: 34 Degrees Fahrenheit - Location: cooler - deli meat
Violation Issued: No

Process/Item: Cold Holding
Temperature: 32 Degrees Fahrenheit - Location: cooler - deli meat
Violation Issued: No

Process/Item: Cold Holding
Temperature: 34 Degrees Fahrenheit - Location: cooler - sliced tomatoes
Violation Issued: No

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

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 8075211214 of 09/21/21.

Certified Food Protection Manager: David Lin

Certification Number: FM60327 Expires: 12/01/23

Signed: _____
Danette Kerkow
Restaurant & Dining Manager

Signed: Erin Tibbetts
Erin Tibbetts
Public Health Sanitarian
Metro District Office
651-201-3987
erin.tibbetts@state.mn.us