DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 7, 2023

Licensee
South Grove Lodge Senior Living
1701 22nd Avenue Southwest
Austin, MN 55912

RE: Project Number(s) SL30819015

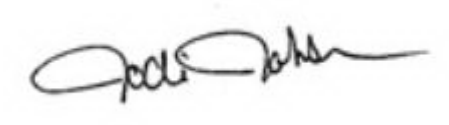
Dear Licensee:

On July 5, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 13, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

JMD

Electronically Delivered

May 2, 2023

Licensee
South Grove Lodge Senior Living
1701 22nd Avenue Southwest
Austin, MN 55912

RE: Project Number(s) SL30819015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 13, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH

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 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $3,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30819	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH GROVE LODGE SENIOR LIVING	1701 22ND AVENUE SW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30819015 On April 10, 2023, through April 13, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 62 active residents; 30 receiving services under the Assisted Living license. 0510: An immediate correction order was issued on April 11, 2023. The immediacy was removed on April 11, 2023; however, non-compliance remains at a level 3, widespread scope (I). 1290: An immediate correction order was issued on April 13, 2023. The immediacy was removed on April 11, 2023; however, non-compliance remains at a level 3, widespread scope (I).	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.	

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0 430	Continued From page 1	0 430		
0 430 SS=A	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to 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 interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for two of three residents (R2 and R4). 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 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).	0 430		

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0 430	Continued From page 2 The findings include: R2 and R4's records lacked evidence the resident received a copy of the licensee's UDALSA 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 R2 R2's diagnosis included chronic obstructive pulmonary disease (inflammatory lung disease that causes airflow blockage and breathing related problems). R2's Service Plan dated March 31, 2023, indicated R2 received services including supervision for brushing teeth, activity reminders, fall monitoring, meal escorts, set-up and cueing for grooming, stand-by assistance for dressing, monthly vitals checked, light housekeeping and assistance with medication administration. R4 R4's diagnoses included diabetes and hypertension (high blood pressure). R4's Service Plan dated January 21, 2023, indicated R4 received services including meal escorts, twice weekly standby bathing assistance, daily wellness check, monthly vitals checked, light	0 430		

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0 430	Continued From page 3 housekeeping, and medication assistance. R2 and R4's record included a signature page to indicate R2 and R4 had received the UDALSA on April 10, 2023 (survey start date). On April 12, 2023, at 10:35 a.m. licensed assisted living director in residence/clinical nurse supervisor (LALDIR/CNS)-A stated R2 and R4 had not received the UDALSA until after the surveyor had entered and requested R2 and R4's records to review on April 10, 2023. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 480		

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0 480	Continued From page 4 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 11, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=I	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. 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. This had the potential to affect all residents, staff, and visitors. This resulted in an immediate correction	0 510		

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0 510	Continued From page 5 order on April 11, 2023, at 1:18 p.m. In addition, the licensee failed to comply with accepted health care, medical and nursing standards for infection control related to glove use and handwashing. 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: On April 10, 2023, at 2:17 p.m. clinical nurse supervisor (CNS)-A stated the facility currently had two residents who had tested positive for COVID-19: R5 and R6. On April 11, 2023, at 8:56 a.m. the surveyor observed a plastic three-drawer cart outside of R6's room that had hand sanitizer and face shields on top. The cart contained disposable gowns, gloves, surgical masks, and N95 masks. There was a droplet and contact precaution sign on the door indicating the resident was in isolation. A garbage can was observed sitting in the hallway outside of the room next to the three-drawer plastic cart. On April 11, 2023, at 9:05 a.m. the surveyor observed a plastic three-drawer cart outside of R5's room that had gloves, face shields, disposable masks. There were no N95 face masks or gowns observed in the cart. In addition, a garbage can was observed sitting in the hallway outside of the room next to the three-drawer	0 510		

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0 510	Continued From page 6 plastic cart. On April 11, 2023, at 9:10 a.m. the surveyor observed a plastic three-drawer cart outside of R7's room that had hand sanitizer, face shields, gowns, gloves, and surgical face masks. There were no N95 face masks in the cart. In addition, a garbage can was observed sitting in the hallway outside of the room next to the three-drawer plastic cart. On April 11, 2023, at 9:21 a.m. unlicensed personnel (ULP)-B stated a gown, gloves, face shield and surgical face mask was required to enter a COVID positive room. ULP-B indicated the facility had N95 masks available, but ULP-B stated she would only wear a surgical mask into a COVID positive room because she had not passed the N95 fit testing. ULP-B stated she would change her surgical mask when exiting room. ULP-B further confirmed personal protective equipment (PPE) is removed in the hallway and thrown away in the garbage next to the three-drawer cart. On April 11, 2023, at 9:23 a.m. ULP-C stated she wears gown, gloves, face mask and a surgical mask. ULP-C stated N95's are available but does not wear them because she has difficulty breathing with the N95 on. ULP-C further confirmed when exiting a COVID positive resident room, she always removed and disposed of the contaminated PPE in the hallway and placed in garbage next to the three-drawer cart. On April 11, 2023, at 12:05 p.m. CNS-A confirmed the facility had PPE including N95 masks and gowns available for ULP's to utilize when going into COVID positive resident rooms. CNS-A indicated the COVID positive residents (R5, R6,	0 510		

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0 510	Continued From page 7	0 510		

and R7) were isolated and clustered to the far end of the building, and those residents usually sat together for meals. CNS-A further confirmed staff should be wearing face shield, gown, gloves, and an N95 mask when entering the room of a COVID positive resident. In addition, CNS-A stated all PPE should be removed and discarded inside the room at doorway before exiting the resident room.

The licensee's PPE Policy revised July 30, 2021, indicated to remove all PPE before exiting the resident's room.

The licensee's Infection Control Program policy dated August 1, 2021, indicated the facility would maintain an infection control program consistent with the Center for Disease Control and Prevention (CDC).

Minnesota Department of Health COVID-19 Source Control (Masking, PPE, and Testing Grid) dated November 2, 2022, identified a resident with a positive COVID-19 test requires full COVID-19 PPE: respirator, eye protection, isolation gown, and gloves.

No further information was provided.

TIME PERIOD FOR COMPLETION: Immediate

GLOVE USE AND HAND WASHING
On April 11, 2023, at 8:33 a.m. ULP-C was observed to prepare and administer R9's medications. Without sanitizing or washing hands, ULP-C put gloves on and administered an eye drop to R9. ULP-C returned to the medication cart and removed the gloves. Without sanitizing or washing her hands, ULP-C

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0 510	Continued From page 8	0 510		

proceeded to prepare R9's oral medications, poured a glass of water from the pitcher on the med cart, and handed the medications to R9. ULP-C stated R9 would get two more eye drops but they needed to be five minutes apart. After R9 took his medications, ULP-C returned to the medication cart and obtained another eye drop for R9. Without washing hands, sanitizing, or applying gloves, ULP-C returned to R9 and administered the second eye drop. ULP-C returned to the medication cart and without sanitizing or washing hands, proceeded to prepare and administer medications to R10. ULP-C returned to the medication cart and proceeded to obtain R9's last eye drop. ULP-C administered R9's eye drop without wearing gloves, and without washing or sanitizing their hands. ULP-C did not wash or cleanse her hands with sanitizer throughout the entire observation.

On April 11, 2023, at 8:50 a.m. ULP-C stated she "usually wore gloves" when administering eye drops and acknowledged that she had not done this. In addition, ULP-C stated she had not washed or sanitized her hands between the steps as noted above and should have.

On April 11, 2023, at 11:05 a.m. ULP-C was observed to prepare and administer R4's insulin. Without washing or sanitizing her hands, ULP-C put gloves on and obtained R4's Humalog insulin pen from the medication cart, removed the cap of the insulin pen, cleansed the end of the insulin pen with an alcohol pad, and applied a new needle. ULP-C primed the insulin pen by wasting two units, dialed the pen to six units, and administered the insulin. Following the injection, ULP-C removed the needle, placed it in the sharps container, removed her gloves, documented the administration, and put the

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0 510	Continued From page 9 insulin back into the medication cart. ULP-C had not washed or sanitized her hands before applying, or after removing the gloves. On April 11, 2023, at 11:15 a.m. ULP-C acknowledged she had not washed or sanitized her hands prior to applying the gloves or after removing the gloves. ULP-C indicated she "should have". On April 12, 2023, at 3:45 p.m. CNS-A stated gloves should be worn for eye drop administration and hands should be washed or sanitized before putting on and taking off gloves, and in between resident tasks. The licensee's Medication Eye Drops policy dated August 1, 2021, identified the following steps: 4. Wash hands and put on gloves 17. Remove gloves and wash hands The licensee's Hand Hygiene policy dated August 24, 2021, indicated: Handwashing is the single most effective way of controlling the spread of infection. Use of gloves does not replace hand washing. Soap and water must be used when hands look dirty, after using the bathroom, and prior to preparing food. In other situations, alcohol-based hand sanitizers may be used instead of soap and water. Hands should be washed or decontaminated: a. before and after direct contact with a resident d. after removing gloves or gowns. No further information provided. On April 13, 2023, the immediacy of correction order 0510 was removed based on surveyor	0 510		

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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
0 510	Continued From page 10 observations and record review by evaluation supervisor; however, non-compliance remains at a scope and level of (I). TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a	0 550		

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0 550	Continued From page 11 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to post information about the facilities' grievance procedure, and the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. On April 10, 2023, at 12:56 p.m. during the facility tour, the surveyor noted a glass enclosed bulletin board by the main entrance and mailboxes that contained required postings. Though there were blank grievance forms laying by the mailboxes, there was no posted facility grievance procedure. On April 10, 2023, at 4:08 p.m. licensed assisted living director in residence/clinical nurse supervisor (LALDIR/CNS)-A confirmed the content noted above was not posted as required. The licensee's Grievance and Complaint policy dated November 1, 2018, identified the following: 2. The process for raising and addressing grievances and complaints will be posted in a visible on-site location along with full contact information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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

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0 680	Continued From page 13 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's EP plan included a hazard and vulnerability assessment and various policies/procedures dated as reviewed February 7, 2023. The licensee's plan lacked the following required content: - A policy to address the use of volunteers, including the process/role for integration. On April 13, 2023, at 2:20 p.m. licensed assisted living director in residence/clinical nurse supervisor (LALDIR/CNS)-A verified the licensee lacked a policy for volunteers in relation to the emergency preparedness plan and Appendix Z to include the above requirement. The licensee's Emergency Preparedness policy dated August 1, 2021, included the facility would establish procedures to save human life, minimize property damage, prevent, and treat injuries, and render maximum assistance to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 730	Continued From page 14	0 730		
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 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	0 730		

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0 730	Continued From page 15 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional	0 730		

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0 730	Continued From page 16 status. R1 was admitted to the facility on May 20, 2017, with a diagnosis of hypertension and was discharged on November 26, 2022, to a different facility for a higher level of care. R1's observation notes dated November 26, 2022, at 3:15 p.m. included: "Resident discharged to higher level of care after hospitalization. All medications returned to pharmacy for credit." On April 10, 2023, at 4:24 p.m. licensed assisted living director in residence/clinical nurse supervisor (LALDIR/CNS)-A stated the licensee did not do a discharge summary other than making an entry in the observation notes. LALDIR/CNS-A further noted none of the licensee's discharged residents would have these required contents documented. LALDIR/CNS-A indicated a new form would need to be developed to include the required components. The licensee's Discharge Summary policy dated August 24, 2021, noted a discharge summary would be written by the time of discharge. The discharge summary would include, if applicable: a. Summary of the resident's stay that including i. Diagnoses ii. Course of illnesses iii. Allergies iv. Treatments v. Therapies vi. Pertinent lab results vii. Pertinent radiology results viii. Pertinent consultation results ix. Final summary of the resident's status. The summary will be based upon the latest assessment or review and, if applicable, will include resident status including baseline and	0 730		

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0 730	Continued From page 17 current mental, behavioral, and functional status. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 800		

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0 800	Continued From page 18 On April 12, 2023, approximately from 11:00 a.m. to 1:00 p.m., survey staff toured the facility with the director of maintenance (DM)-D. During the tour, survey staff observed the following: 1. Improper use of electrical power strips inside the 2nd-floor mechanical/maintenance office room. Three power strips were plugged into other power strips near (also known as daisy chaining). Improper use of power strips and the use of unlabeled and unlisted extension cords pose potential electrical fire hazards from overloading the circuits. 2. The fire-rated door for the second-floor laundry room (building C) failed to positively latch when closed. All fire-rated doors must be in proper working order to maintain the integrity and the rating of the room and the corridor to protect the residents, staff, and visitors during a fire. 3. A water treatment appliance/dispenser located in the first-floor neighborhood serving kitchen (building C) had a backwash discharge pipe connected to the fixture drain (inlet side of trap) of the hand sink posed cross-connection and contamination to the drinking water dispenser/system. Survey staff explained to the DM-D all water softener equipment and drinking treatment/dispensers must discharge to waste by means of an approved airgap. 4. The washer standpipe receptors in closets of resident rooms (throughout the facility) were not used to receive indirect waste from clothes washers or properly capped to prevent sewer gas from entering the rooms from traps being dried out. Survey staff noted and DM-D agreed that most residents did not have their own clothes washers and utilized the central/common laundry rooms for laundry needs. Survey staff explained to the DM-D that plumbing standpipe traps were not capped off to prevent allow sewer gas to	0 800		

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0 800	Continued From page 19 enter the building environment creating exposure to potential health risks over time to residents and employees. 5. In the resident two-bedroom apartment unit 101: -Carpet flooring throughout the unit was soiled and stained. -Ants were observed near the patio sliding doors. -The plumbing toilet trap inside a bedroom (master) was completely dried out, which would allow sewer gas to enter the building. The DM-D confirmed by flushing the toilet and explained that the toilet/bathroom had probably been used for a while. 6. In the sprinkler riser room, the ceiling had some cutout sheet rocks from repairs that needed to be repaired and caulked with approved fire sealant. In addition, the heat detector near the ceiling was observed to be unsecured and hung down from the ceiling with wires exposed. All listed deficiencies were visually and/or verbally verified by the DM-D accompanying the tour. On April 12, 2023, at approximately 1:30 p.m., during the exit interview, the licensed assisted living director in residence/clinical nurse supervisor (LALDIR/CNS)-A and the DM-D acknowledged the above findings. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 20 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the complete content of the fire safety and evacuation plan and the minimum frequency of employee evacuation drills. This has the potential to directly	0 810		

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0 810	Continued From page 21 affect the safety of all residents receiving services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 12, 2023, approximately from 11:00 a.m. to 1:00 p.m., survey staff toured the facility with the director of maintenance (DM)-D. On April 12, 2023, at approximately 1:00 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the director of maintenance (DM)-D. At approximately 1:30 p.m., document review and interview with licensed assisted living director in residence/clinical nurse supervisor (LALDIR/CNS)-A and the DM-D indicated the following findings: 1. The evacuation floor layouts posted near the elevators lacked the locations, numbers of sleeping rooms, and building exits. The finding was evident as a site plan layout was used with red markings posted near the elevators. In addition, in the emergency preparedness 3-ring binder, the wildfire escape floor plans did not include a second-floor plan layout. During the interview with the DM-D and the LALDIR/CNS-A verified that the fire safety and evacuation plan for the facility lacked these provisions. 2. No resident fire protection emergency	0 810		

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0 810	Continued From page 22	0 810		

procedures. The LALDIR/CNS-A verified the finding after further review of the resident handbook (12/2021) with content on fire drills but no relevant information on resident fire protection procedures.
3. The licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation. No record was provided or available for review.
4. The licensee lacked the required minimum employee training specifically on the fire safety and evacuation plan twice a year after new hire orientation for fire safety and evacuation. Records were requested but survey staff received one all-staff training sign-in sheet dated, March 7, 2023, for review. Survey staff explained to the LALDIR/CNS-A and the DM-D that the record lacked training content and did not substantiate the required fire safety and evacuation training.
5. Drill record review showed an insufficient number of employee fire evacuation drills performed to date. One fire drill record was provided for review, on March 27, 2023 (2:00 p.m.). The fire drill record also lacked evacuation information as the documentation had not included any evacuation notes and/or details. Survey staff explained to the LALDIR/CNS-A and the DM-D that evacuation drills must be included in the fire drills, and the minimum required frequency of two fire evacuation drills for employees is twice per year per shift with at least one evacuation every other month, totaling six evacuation drills per year that must be carried out to meet the requirements.

On April 12, 2023, at approximately 1:40 p.m., during the exit interview, the LALDIR/CNS-A and the DM-D acknowledged the above findings.

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0 810	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 900 SS=D	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, a new contract or an addendum to the existing contract must be executed and signed.	0 900		

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0 900	Continued From page 24 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract prior to providing assisted living services for two of three residents (R3, R4). 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 and R4's records lacked a written contract with the following required content: (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. R3 R3 diagnosis included congestive heart failure (impairment of the heart's blood pumping function). R3's Service Plan dated January 23, 2023, indicated R3 received services including	0 900		

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0 900	Continued From page 25 reminders to brush teeth, and use hearing aids, meal escorts, stand-by assistance for transfers, dressing, grooming shaving, twice weekly bathing, toileting assistance, monthly vitals check, wellness checks, light housekeeping, and medication assistance. R4 R4's diagnoses included diabetes and hypertension (high blood pressure). R4's Service Plan dated January 21, 2023, indicated R4 received services including meal escorts, twice weekly standby bathing assistance, daily wellness check, monthly vitals checked, light housekeeping, and medication assistance. R3 and R4's record included a Resident Agreement (identified as the assisted living contract) dated April 10, 2023 (survey start date). On April 12, 2023, at 10:35 a.m. licensed assisted living director in residence/clinical nurse supervisor (LALDIR/CNS)-A stated R3 and R4 had not received a contract until after the surveyor had entered and requested R3 and R4's records on April 10, 2023. LALDIR/CNS-A further stated she would need to do audits to see what residents were missing contracts and other required paperwork as she was new to position and was not aware some were lacking. The licensee's Filing and Retention of Contract policy dated August 24, 2021, indicated the contract and related documents must be maintained by the facility in files from the date of execution until five years after the contract is	0 900		

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0 900	Continued From page 26 terminated or expires. The contracts and all associated documents must be available for on-site inspection by the commissioner at any time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	0 970		

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0 970	Continued From page 27 The findings include: The licensee's assisted living contract included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. The Resident Agreement (identified as the contract) included on page thirteen (13) the following: -"A. Indemnification. As an occupant of the community, you assume the risk of your own safety and for the safety of your guests and agents. You will indemnify and hold harmless us, our employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of you or your guests or agents." On April 12, 2023, at 10:40 a.m. licensed assisted living director in residence/clinical nurse supervisor (LALDIR/CNS)-A verified the content listed above, and said the same contract was utilized for all residents. LALDIR/CNS further stated the corporate office was working on changing the language of the contract but had not been implemented for the licensee's current residents yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

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01290	Continued From page 28	01290		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for one of three employees (unlicensed personnel (ULP)-B). This resulted in an immediate correction order on April 13, 2023, at 10:37 a.m. In addition, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for two of two employees (ULP-C and ULP-F). This had the potential to affect all residents currently receiving services within the facility. 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	01290		

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01290	Continued From page 29 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: ULP-B ULP-B had a hire date of November 2, 2022. ULP-B's employee record included a Final Registry Results Form dated November 2, 2022, from the Minnesota Department of Human Services (DHS); however, lacked evidence of a background clearance as required. On April 11, 2023, at 8:20 a.m. ULP-B was observed to independently administer medications to R8 in his room. ULP-C ULP-C had a hire date of August 30, 2022. ULP-C's employee record contained a background study clearance notice dated October 28, 2022, for a separate location operated by the licensee's owner. ULP-C's employee record lacked evidence the licensee affiliated a background study for their license. ULP-F ULP-F had a hire date of July 25, 2022. ULP-F's employee record contained a background study clearance notice dated November 21, 2022, for a separate location operated by the licensee's owner. ULP-F's employee record lacked evidence the licensee affiliated a background study for their license.	01290		

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01290	Continued From page 30 On April 13, 2023, at 10:33 a.m. licensed assisted living director in residence/clinical nurse supervisor (LALDIR/CNS)-A confirmed ULP-B had not been cleared for her background study as she had not completed the fingerprinting process in the required time frame. LALD/CNS-A stated she was not employed when ULP-B was hired and not aware a background study had not been completed. LALD/CNS-A further stated ULP-B had been working independently. In addition, LALDIR/CNS-A verified ULP-C and ULP-F's background studies had been submitted under different licenses and they had not been affiliated to the licensee's assisted living facility license. The licensee's Background Checks policy dated August 24, 2021, indicated all employees; as well as contractors, and regularly scheduled volunteers of the community with direct resident contact with undergo a background study through DHS. Only those with satisfactory results will continue to work with the community and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On April 13, 2023, the immediacy of correction order 1290 was removed based on surveyor observations and record reviews by the evaluation supervisor; however, non-compliance remains at a scope and level of (I). TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 31 (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 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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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 a written service plan was revised to reflect the current services provided for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01640		

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01640	Continued From page 32 The findings include: R3's diagnosis included congestive heart failure (impairment of the heart's blood pumping function). R3's Service Plan dated January 23, 2023, indicated R3 received services including reminders to brush teeth and use hearing aids, meal escorts, stand-by assistance for transfers, dressing, grooming, twice weekly bathing, toileting assistance, monthly vitals check, wellness checks, light housekeeping, and medication assistance. The service plan failed to identify the treatment of TED (thrombo-embolic deterrent) socks (compression socks used to increase circulation to prevent swelling) assistance. R3's prescriber order dated April 5, 2023, included an order for compression socks during the day, off at night. On April 12, 2023, at 10:25 a.m. unlicensed personnel (ULP)-C stated staff apply TED socks to R3 every morning and remove them each evening. On April 12, 2023, at 12:53 p.m. R3 was observed wearing bilateral TED socks. On April 12, 2023, at 4:00 p.m. licensed assisted living director in residence/clinical nurse supervisor (LALDIR/CNS)-A stated she was unable to update the service plan without doing a new assessment, and this had not been done. LALDIR/CNS-A verified R3's service plan failed to include the treatment of TED socks and should have been updated so the current services would	01640		

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01640	Continued From page 33 be reflected on the service plan. The licensee's Resident Evaluation and Service Plan policy dated revised March 10, 2023, indicated as a resident's condition changes, resulting in a change in care needs, the service plan should be updated to reflect those changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure time sensitive medications were dated when opened for one of one resident (R4) with insulin. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01890		

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01890	Continued From page 34 The findings include: On April 11, 2023, at 11:05 a.m. the surveyor observed the medication cart with unlicensed personnel (ULP)-C. R4's Humalog (fast acting insulin) KwikPen lacked a date to indicate when staff opened it, or when it would expire. ULP-C confirmed the findings and verified insulin pens should be dated when opened and when they would expire. On April 12, 2023, at 3:50 p.m. licensed assisted living director in residence (LALDIR/CNS)-A confirmed insulin should be dated when opened. The Humalog KwikPen insulin manufacturer's instructions for use revised April 2020, noted: Throw away the Humalog pen you are using after 28 days, even if it still has insulin left in it. The licensee's Storage and Handling Medications policy dated August 24, 2021, noted medications would be stored per acceptable standards. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	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	01910		

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01910	Continued From page 35 part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication strength and prescription numbers as applicable, for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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's Observation note dated November 26, 2022,	01910		

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01910	Continued From page 36 indicated R1 discharged on November 26, 2022, to another facility for a higher level of care. R1's Discharge/Leave of Absence Medication form dated November 26, 2022, included documentation that all medications were returned to pharmacy for credit upon discharge. The document had columns that identified the medication name/strength, dosing route, dosing instructions, amount remaining, amount received, a signature line for resident/responsible party, community staff, and second staff signature line for controlled substance count. The document did not include a column for the prescription number. - The following medications were listed without a strength: acetaminophen (mild-moderate pain reliever) and diclofenac sodium gel (topical join pain reliever); - The following medications were listed without a prescription number: acetaminophen, amlodipine (blood pressure), calcium (supplement), diclofenac sodium gel, hydrocortisone cream (topical cream for swelling, itching and irritation of skin), levothyroxine (thyroid), nortriptyline (anti-depressant), polyethylene glyco (constipation), and pregabalin (nerve pain). On April 10, 2023, at 4:20 p.m. licensed assisted living director in residence/clinical nurse supervisor (LALDIR/CNS)-A confirmed R1 received medication management services and stated the facility's Discharge/Leave of Absence Medication form did not include an area for the prescription number as required. LALDIR/CNS-A further indicated none of the facility's disposition records would have the prescription number listed and acknowledged the acetaminophen and diclofenac sodium gel strengths were missing on the form, indicating it should have been included.	01910		

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01910	Continued From page 37 The licensee's Disposition or Disposal of Medication policy dated August 24, 2021, noted documentation of the destruction, listing the date, quantity, name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the resident's record for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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	01940		

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SOUTH GROVE LODGE SENIOR LIVING	1701 22ND AVENUE SW AUSTIN, MN 55912

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01940	Continued From page 38 (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 10, 2023, at 12:15 p.m. licensed assisted living director in residence/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment management services to residents, including compression stockings. R3's diagnosis included congestive heart failure (impairment of the heart's blood pumping function).	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30819	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH GROVE LODGE SENIOR LIVING	1701 22ND AVENUE SW AUSTIN, MN 55912

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01940	Continued From page 39 R3's Service Plan dated January 23, 2023, indicated R3 received services including reminders to brush teeth, and use hearing aids, meal escorts, stand-by assistance for transfers, dressing, grooming, twice weekly bathing, toileting assistance, monthly vitals check, wellness checks, light housekeeping, and medication assistance. The service plan failed to identify the treatment of TED (thrombo-embolic deterrent) socks (compression socks used to increase circulation to prevent swelling) assistance. On April 12, 2023, at 10:25 unlicensed personnel (ULP)-C stated staff applied TED socks to R3 every morning and removed them each evening. On April 12, 2023, at 12:53 p.m. R3 was observed wearing compression socks to bilateral lower extremities. R3's prescriber orders dated April 5, 2023, included an order for compression stockings during the day, off at night. R3's Recorded Care Report dated April 12, 2023, included TED Hose total assist every a.m.; TED Hose total assist every p.m. Though R3's record contained an Individualized Treatment and Therapy Management Plan dated January 23, 2023, R3's records lacked a treatment management plan to include the following required content for the use of TED socks: - documentation of specific resident instructions relating to the treatments or therapy administration; - procedures for notifying a registered nurse when	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30819	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 40 a problem arose with treatments or therapy services. In addition, R3's service plan did not include the treatment of TED hose. On April 12, 2023, at 4:00 p.m. licensed assisted living director in residence/clinical nurse supervisor (LALDIR/CNS)-A stated R3's treatment order was new on April 5, 2023, and she had not yet completed components of the individualized treatment plan to include resident specific instructions and when to notify a nurse. The licensee's Development of the Individualized Medication, Treatment, and Therapy Management Plans policy dated May 20, 2022, indicated a registered nurse (RN) would develop a treatment management plan for each resident receiving treatment management services. The treatment management plan would include: a. Statement of the type of services provided; b. Documentation of specific resident instructions relating to the treatments; c. Identification of treatment tasks that may be delegated to an unlicensed staff member; d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises withe treatments; e. Resident-specific requirements relating to documentation of treatment received, verification that all treatment was administered as prescribed, and monitoring of treatment to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30819	A. BUILDING: _____ B. WING _____	04/13/2023

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

Type: Full
Date: *04/11/23*
Time: 09:38:30
Report: 8044231121

Food and Beverage Establishment Inspection Report

Location:
South Grove Lodge Senior Livin
1701 22nd Avenue Sw
Austin, MN55912
Mower County, 50

Establishment Info:
ID #: 0037740
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074340600
ID #:

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

The following orders were issued during this inspection.

5-200B Plumbing: cross connections

5-203.14A ** Priority 1 **

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

No air gap for water softener discharge hoses.

Comply By: 04/25/23

5-400 Sewage

5-402.11A ** Priority 1 **

MN Rule 4626.1190A Provide an indirect connection between the sewage system and any drain originating from equipment in which food, portable equipment or utensils are placed, such as manufacturing and retail display equipment, portable equipment, ice bins, salad bars, cocktail stations and dipper wells.

Dipper well in ice parlor not drained with an air gap.

Dipper well use may be swapped with a heater dipper well.

Comply By: 04/11/23

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

Food residues on blade of can opener.

Can opener cleaned on site.
Comply By: 04/11/23

4-400 Equipment Location and Installation

4-402.11A

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

No sealant for dishwashing sink backsplashes.
Comply By: 05/11/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

Failing wooden hollow-base cabinets in kitchen are falling apart and no longer easy to clean.
Comply By: 04/11/26

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

Missing base tile in steamer area.

Damaged wall next to freezer 3.

Peeling paint on walls behind freezer 2.
Comply By: 05/11/23

Surface and Equipment Sanitizers

Chlorine: = 50 ppm at Degrees Fahrenheit
Location:
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 184.7 Degrees Fahrenheit - Location: Taco meat
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39.0 Degrees Fahrenheit - Location: Upright 1
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40.1 Degrees Fahrenheit - Location: Ham in upright 1
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39.9 Degrees Fahrenheit - Location: Diced tomatoes in upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39.0 Degrees Fahrenheit - Location: Upright 4
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41.3 Degrees Fahrenheit - Location: Milk in upright 4
Violation Issued: No

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

HRD Inspection conducted with lead evaluator Susan Kalis. Inspection report reviewed on site with Director of Dining Services, Lora.

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 8044231121 of 04/11/23.

Certified Food Protection Manager: Lora L. McCaulley

Certification Number: FM3427 Expires: 08/16/24

Inspection report reviewed with person in charge and mailed.

Signed: _____
Inspector signed for Lora

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