Electronically Delivered

August 28, 2023

Licensee
Spring Valley Estates
815 Memorial Drive
Spring Valley, MN 55975

RE: Project Number(s) SL30563015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 10, 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 - $500.00

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

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30563	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ESTATES	815 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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: SL30563015-0 On August 7, 2023, through August 10, 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 28 active residents; 28 were receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 7, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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	0 510		

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0 510	Continued From page 2 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 effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by two of four unlicensed personnel (ULP-F, ULP-G) between resident contact, personal cares and medication administration. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: ULP-F On August 8, 2023, at 7:01 a.m. ULP-F was observed to assist R7 in the bathroom. Without cleansing/sanitizing her hands, ULP-F applied gloves, wiped sweat from her face, and pushed her hair back. ULP-F applied lotion to R7's legs and changed R7's incontinent brief, removed her gloves, and without cleansing/sanitizing her	0 510		

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0 510	Continued From page 3 hands, applied new gloves. ULP-F lotioned R7's back, changed upper body clothes, put shoes on, provided peri-care, and then removed gloves but did not perform hand hygiene. ULP-F washed R7's glasses, applied deodorant, fixed shoe, put laundry away, and combed R7's hair. At 7:15 a.m., ULP-F went to R7's medication cabinet, without cleansing/sanitizing hands, applied gloves, punched medications from bubble packs, administered oral medications and eye drops. ULP-F removed the gloves and left R7's room without performing hand hygiene. At 7:22 a.m. ULP-F was observed to enter R8's room for medication administration. ULP-F applied gloves without cleansing/sanitizing her hands and assisted R8 to transfer from the recliner to her wheelchair and then to the toilet. ULP-F applied clean gloves, provided peri-care, and assisted R8 from the toilet to the wheelchair, removed gloves and used hand sanitizer. ULP-F then assisted R8 with changing clothes, assisted again with a transfer, touched her face and wiped sweat with her hands, and brought R8 to the dining room without performing hand hygiene between steps and wiping sweat from her face. On August 8, 2023, at 9:21 a.m. ULP-F stated hand hygiene should be completed prior to entering a resident's room, before and after glove use. ULP-F stated she usually used hand sanitizer until she could get to a sink and wash her hands. ULP-F confirmed she did not practice proper hand hygiene during observation. ULP-F stated she was unaware that she touched her face while wearing gloves and should have removed her gloves and performed hand hygiene before she continued. ULP-G On August 8, 2023, at 7:45 a.m. ULP-G was	0 510		

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0 510	Continued From page 4 observed to apply gloves and assist clinical nurse supervisor (CNS)-C transfer R2 from his bed to the toilet via an EZ-stand (mechanical lift). With the same gloves, ULP-G set up and administered medications to R2's wife (R9). ULP-G then continued with tasks in the room, brought clean laundry from the laundry room, helped dress R2, changed the bathroom garbage liner and assisted to transfer R2 from the toilet to his wheelchair. With the same gloves, ULP-G emptied R2's urinary catheter bag, rinsed the urine receptacle, and set up R2's medications. With the same gloves, ULP-G referenced the electronic Medication Administration Record (eMAR) on his tablet, opened the medication cupboard, set up and administered R2's oral medications, nasal spray, documented medication administration, applied diclofenac gel (topical pain gel) to R2's back and removed gloves. Without hand hygiene, ULP-G assisted R2 with putting on shoes, pushed R2 to the dining room in his wheelchair, took R2's garbage from his room to the trash room, pushed chairs around in the dining room and then used hand sanitizer. On August 8, 2023, at 9:15 a.m. ULP-G was observed to enter R2's room to complete a blood sugar check. ULP-G applied clean gloves, prepped the glucometer (a monitor used to read blood sugar levels), wiped R2's left index finger with an alcohol wipe and poked the finger for a sample of blood. With the same gloves, ULP-G documented R2's blood sugar level (236) on his tablet. With the same gloves, ULP-G set up and administered R2's insulin. ULP-G then removed his gloves, but did not perform proper hand hygiene before leaving R2's apartment. On August 8, 2023, at 1:45 p.m. CNS-C stated her expectation was for staff to use proper hand	0 510		

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0 510	Continued From page 5 hygiene between resident contact, between steps of resident cares, immediately following potential contact with blood, and following the use of gloves. The licensee's Procedure for Using Gloves dated July 2023, indicated that gloves were to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item such as soiled linen for wound dressings. Gloves would be removed carefully, disposed of in a proper container and rewash hands. The licensee's Hand Hygiene policy dated July 2023, indicated handwashing should be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves did not replace handwashing. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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	0 550		

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0 550	Continued From page 6 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 the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. 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: On August 7, 2023, at 1:20 p.m. the surveyor observed the licensee's Tenant Grievance/Complaint Procedures dated June 2017, and a Grievance/Complaint Form, found in the entryway of the facility and on a bulletin board in the assisted living dining area. The Grievance/Complaint Form included a Grievance Procedure that read, "If you or your	0 550		

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0 550	Continued From page 7 representative has a grievance or complaint relating to any area of your care, please bring your concern to one of the following: Housing Coordinator, Housing Manager, Housing Staff Managers, or Monthly Tenant Meeting. If you are not satisfied with the results you received from your grievance, verbally and in writing when possible, to: The Administrator (included a phone number). If remain unsatisfied after the following procedure, contact: Office of Ombudsman for Older Minnesotans (included the address and phone number) or the Office of Health Facility Complaints (included address and phone number)." The licensee failed to post the required information about the facilities' grievance procedure, to include the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. Additionally, the posting lacked contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. On August 7, 2023, at 2:50 p.m. licensed assisted living director (LALD)-B reviewed the posted documents and the required content, and stated she would look for an updated document; however, she was unable to locate anything updated. LALD-B updated their policy and posted information to include the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 620	Continued From page 8	0 620		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (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 licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) for a significant set of medication errors for one of one resident (R5). 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 service plan dated March 27, 2023, indicated she received services to include medication administration. The licensee's Medication Error reports dated July 13, 2023, at 10:14 a.m. indicated four medication errors in five days: -Dates of medication errors-July 7, 2023, July 8, 2023, July 10, 2023, and July 11, 2023. -Medications involved-warfarin 3 milligrams (mg).	0 620		

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0 620	Continued From page 9 -Description of error-medication charted as given but pills still in medication card. -Reason for the medication error-failure to verify correct resident/medication/time/route. -Was the medical provider contacted-Yes-anticoagulation clinic -If "yes", what was the response of the MD- give 4 mg warfarin tonight (July 13, 2023) and keep appointment to recheck International Normalized Ratio (INR)-a blood clotting test used to measure how quickly blood forms a clot) tomorrow (July 14, 2023). -Actions taken to prevent future errors-Education will be provided to all staff. Change made to ensure verification process for all pills separately verses [vs] charting in the dosage box. The licensee's Medication Error reports dated July 18, 2023, at 1:24 p.m. indicated two additional medication errors involving warfarin: -Dates of medication errors-July 15, 2023, and July 16, 2023. -Medication involved-warfarin 3 mg. -Description of medication errors-not given to tenant [resident]. Medication was still in the punch card. -Was the medical provider contacted-Yes-anticoagulation clinic -If "yes" what was the response of the MD-anticoagulation clinic notified and advised to make changes to rest of week doses -Actions taken to ensure the well-being of the resident-Changed times to 4:00 p.m. so is the only medication given at that time and advised staff to call nurse when administering. The licensee failed to report the series of significant medication errors to MAARC. On August 9, 2023, at 11:40 a.m. clinical nurse	0 620		

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0 620	Continued From page 10 supervisor (CNS)-C stated she had looked into the pattern of errors with R5's warfarin and found with the first set of missed doses (July 7, 8, 10, 11, 2023), a system upgrade with RTasks (the licensee's electronic medical record system) caused a glitch in the eMAR which identified a "virtual mediset" in which the unlicensed personnel (ULP) did not recognize the need to administer the warfarin. Even though the warfarin was in R5's medication box, it was not questioned. CNS-C stated they had corrected this glitch in the system. With the second set of missed doses (July 15, 2023, and July 16, 2023), the same ULP missed the warfarin administration and was not certain why the doses were missed. CNS-C stated as an effort to mitigate future errors, she moved R5's warfarin from 8:00 p.m. to 4:00 p.m. so it was the only medication given and the ULP were to notify nursing when the warfarin was given. CNS-C stated she made the proper calls to the anticoagulation clinic to report the errors, and to family. She stated R5's INR had been subtherapeutic (out of the intended range to prevent blood clots) since her admission on March 27, 2023. The medication errors created additional warfarin dose adjustments and additional lab work/trips to the clinic in Rochester were required. CNS-C stated she had not considered filing a MAARC report as she didn't feel this was a case of abuse but had not thought of neglect. The licensee's Vulnerable Adult Maltreatment Policy dated February 8, 2023, indicated the organization would create an environment and process to identify, prevent, and mitigate maltreatment of vulnerable adults. No further information was provided.	0 620		

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0 620	Continued From page 11 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 review, the licensee failed to support protection and safety by not posting 911 emergency number as required. 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:	0 640		

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0 640	Continued From page 12 On August 7, 2023, at 1:20 p.m. during a facility tour with licensed assisted living director (LALD)-A and LALD-B, the surveyor noted no 911 emergency number posting in the facility common areas or by facility supplied telephones as required. At 1:25 p.m. LALD-B stated she would look around the facility more, but was not aware of the requirement to post 911 and stated she didn't want the facility to have an "institutional feeling". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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 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	0 650		

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0 650	Continued From page 13 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included evidence of training/competency content for insulin pen injection and lacked a job description for one of two unlicensed personnel (ULP)-G). 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-G's was hired on September 27, 2021, to provide direct care services to residents of the facility. Insulin competency On August 8, 2023, at 9:15 a.m. ULP-G was observed to administer Novolog insulin by injection to R2. ULP-G failed to demonstrate competency with wiping the insulin pen tip prior to attaching a new needle, failed to prime the needle with the required two units of Novolog insulin, failed to cleanse the skin with alcohol and failed to hold the insulin pen in place for the designated	0 650		

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0 650	Continued From page 14 10 seconds during administration. ULP-G stated he was trained by other unlicensed personnel but had been trained and observed with insulin administration by an unnamed registered nurse (RN) in 2021. ULP-G stated he was not aware he should prime the insulin pen needle prior to administration. ULP-G's employee file contained medication administration training/competency records dated and signed by an RN on October 8, 2021, included the skills competency tests for the administration of oral medications, vaginal medication administration, transdermal (skin patch), topical (skin creams), nebulizer, inhalation (breathing) medications, eye drops, eardrops, and rectal medications, but lacked the training/competency for insulin pen injection. Job description ULP-G's employee record lacked evidence of a current job description which included the qualifications for the position and identification of staff providing supervision. On August 9, 2023, at 1:15 p.m. licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-C reviewed ULP-G's employee file and other possible locations for evidence of this training but were unable to locate it. Additionally, LALD-B stated there was no record of a job description in ULP-G's employee file. The licensee's Personnel Records policy dated July 2023, indicated the personnel file would be maintained with record of all required training for unlicensed personnel, competency evaluations and the employee's current job description.	0 650		

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0 650	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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 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 are: On August 8, 2023, approximately from 10:30 a.m. to 12:15 p.m., survey staff toured the facility with the maintenance director (MD)-I. During the	0 800		

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0 800	Continued From page 16 tour, survey staff observed the following: -The memory care laundry room fire-rated door failed to latch when closed to maintain the fire-rated room and required corridor fire separation. -The resident room 52 door failed to latch when closed for resident privacy and to maintain the fire-rated corridor. -The chemical soap dispenser connected to the faucet of the mop sink located inside the memory care housing keeping room was not protected with the proper pressure bleeding device, creating a risk of backflow of chemicals into the potable water supply comprising the building water supply. The MD-I accompanying the facility tour verified the above findings. On August 8, 2023, at approximately 1:15 p.m., at the exit interview, the MD-I and the licensed assisted living director-B acknowledged the above findings. No further 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 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 17 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 required employee training on the fire safety and evacuation plan. This has the potential to directly affect the safety of all residents receiving care, 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	0 810		

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0 810	Continued From page 18 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 August 8, 2023, at approximately 12:15 p.m., survey staff received the fire safety and evacuation documentation, the evacuation/fire drill records, and related documentation for review. At 1:00 p.m., document and interview with the maintenance director (MD)-I indicated that the licensee did not provide the minimum required employee training of twice a year on the fire safety and evacuation plan (after orientation training). Records were requested for training after new hire orientation training on fire safety and evacuation but only received new hire orientation training records. Survey staff advised the MD-I that the minimum required employee training is upon hire and twice a year thereafter. The listed findings were verbally confirmed by the MD-I during the document interview. On August 8, 2023, at approximately 1:15 p.m., at the exit interview, the MD-I and the licensed assisted living director-B acknowledged the above findings. The licensee, licensed assisted living director-A, provided additional resident training records on fire protection and emergency procedures (via email on August 9, 2023, at 10:53 a.m.). TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01290	Continued From page 19	01290		
01290 SS=F	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 submitted and received in affiliation with the assisted living license for two of two employees (unlicensed personnel (ULP)-G, ULP-J). 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:	01290		

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01290	Continued From page 20 ULP-G ULP-G was hired on September 27, 2021, to provide direct care services to the licensee's residents. On August 8, 2023, at 9:15 a.m. the surveyor observed ULP-G check R2's blood sugar and administer an insulin injection. ULP-G's employee record contained a background study dated June 29, 2023, for a separate location (the nursing home attached to the building). ULP-G's record lacked evidence the licensee affiliated a background study for their assisted living with dementia care (ALFDC) license. ULP-J ULP-J was hired on March 13, 2023, to provide direct care services to the licensee's residents. ULP-J's employee record contained a background study dated March 16, 2023, for a separate license (the nursing home attached to the building). ULP-J's record lacked evidence the licensee affiliated a background study for their ALFDC license. On August 9, 2023, at 10:35 a.m. licensed assisted living director (LALD)-B stated she was not aware the employees' background clearance studies were not affiliated with the Assisted Living with Dementia Care license. She stated all employees, between the Assisted living license and the nursing home license, were processed through human resources and thought they were all likely identified with the nursing home license. LALD-B stated she would review the employee files to determine whether this was the case for	01290		

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01290	Continued From page 21 all employees. The licensee's Background Checks dated August 1, 2022, indicated all employees; as well as contractors and regularly scheduled volunteers of the facility with direct resident contact would undergo a background study through the Department of Human Services (DHS). Only those with satisfactory results would continue to work with the facility and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first	01440		

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01440	Continued From page 22 performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of two of two unlicensed personnel (ULP-G and ULP-J) performing delegated tasks was provided within 30 calendar days after the date on which the individuals began working for the licensee. 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-G ULP-G was hired September 27, 2021, to provide direct care services to the residents at the assisted living facility with dementia care (ALFDC). On August 8, 2023, at 9:15 a.m. the surveyor observed ULP-G complete a blood sugar check and administer an insulin injection to R2. ULP-G's employee record did not include a 30-day direct supervisory review.	01440		

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01440	Continued From page 23 ULP-J ULP-J was hired on March 13, 2023, to provide direct care services to the residents at the ALFDC. ULP-J's record did not include a 30-day direct supervisory review. On August 9, 2023, at 1:15 p.m. clinical nurse supervisor (CNS)-C stated she was unable to find evidence that a registered nurse provided a 30-day supervisory observation for either ULP-G or ULP-J. The licensee's Supervision of Unlicensed Personnel policy dated July 2023, indicated unlicensed personnel providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person began work for the facility and had been trained and determined competent to perform all the tasks assigned. The RN would directly supervise the staff performing the delegated nursing tasks. No further information as provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;	01470		

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01470	Continued From page 24 (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased	01470		

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01470	Continued From page 25 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-G, ULP-J) received orientation to assisted living facility licensing requirements and regulations before providing services. 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-G ULP-G was hired on September 27, 2021, to provide direct care services to the licensee's residents. ULP-G's employee record lacked evidence of receiving orientation to assisted living to include the following required content: -review of provider's policies and procedures, -handling of resident complaints, reporting of	01470		

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01470	Continued From page 26 complaints, where to report, -consumer advocacy services; and -principles of person-centered planning/service delivery ULP-J ULP-J was hired on March 13, 2023, to provide direct care services to the licensee's residents. ULP-J's employee record lacked evidence of receiving orientation to assisted living to include the following required content: -review of provider's policies and procedures, -handling of resident complaints, where to report; and -consumer advocacy services On August 10, 2023, at 11:30 a.m. housing coordinator (HC)-K stated she was still trying to understand the training subject requirements and how they were recognized in Relias (the licensee's electronic training module program) and could not speak to ULP-G's training as that occurred before she started the role. Licensed assisted living director (LALD)-B stated the licensee reviewed a few select policies at the time of hire but not all policies that related to the ULP duties. LALD-B stated the documents in the employee files are what the licensee had. The licensee's Assisted Living with Memory Care Orientation-All Staff policy dated July 2023, indicated newly hired staff would receive orientation and training on topics required for assisted living organizations. The requirements included: 2. An introduction and review of agency policies and procedures related to the provision of assisted living services 10. Principles of person-centered planning and	01470		

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01470	Continued From page 27 service delivery and how they apply to direct support services 12. Maltreatment of vulnerable adults 13. How to report maltreatment of vulnerable adults 14. How to report a crime 15. Complaint process a. Handling resident complaints b. The facility's system for receiving and responding to complaints, c. Where and how to report complaints d. Contact information for the Office of Health Facility Complaints e. Contact information for the Office of the Ombudsman for long-term care f. Contact information for the Office of the Ombudsman for Mental Health and Disabilities No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control	01500		

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01500	Continued From page 28 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01500		

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01500	Continued From page 29 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-G). 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-G began providing direct care services on September 27, 2021, under the licensee's assisted living with dementia care license. ULP-G's employee record lacked evidence the employee had successfully completed annual training to include the following: -reporting maltreatment of vulnerable adults or minors; -assisted living bill of rights; -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -principles of person-centered planning/service delivery	01500		

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01500	Continued From page 30 Additionally, ULP-G's training document did not reflect the required eight hours of annual training. On April 10, 2023, at 11:30 a.m. housing coordinator (HC)-K stated she set the training modules for the employees and was still learning the requirements for training and how Relias recognized the required content. The licensee's Assisted Living with Dementia Care-Annual Training policy dated July 2023, indicated: 1. All assisted living employees will complete annual education on the following topics: a. Reporting of maltreatment of vulnerable adults under section 626.557 b. Assisted living bill or rights c. Staff responsibility related to ensuring the exercise and protection in the assisted living bill of rights d. Infection control techniques used in the home and implementation of infection control standards including: - Hand washing - Need for and use of protective gloves, gowns, and masks - Appropriate disposal of contaminated materials and equipment such as dressings, needles, syringes, and razor blades - Disinfecting reusable equipment - Disinfecting environmental surfaces - Reporting communicable diseases e. Effective approaches for problem solving when working with challenging behaviors f. Effective approaches for communication with residents with dementia, Alzheimer's disease or related disorders g. Review of policies and procedures relating to the provision of assisted living services and how to implement them	01500		

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01500	Continued From page 31 h. Principles of person-centered planning and service delivery i. How person-centered planning and service delivery applies to direct support services provided by staff j. Emergency and disaster training 2. Annual training will be documented in accordance with the documentation policy. 3. Direct-care staff will complete 8 hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01540		

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01540	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-G) completed the required number or hours of dementia care training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee had an assisted living with dementia care license dated May 1, 2023. ULP-G ULP-G was hired on September 27, 2021, and provided direct care services to the residents of the facility. On August 8, 2023, at 9:15 a.m. ULP-G was observed to complete a blood sugar check and administer an insulin injection to R2. ULP-G's record included a Relias (the licensee's electronic training module program) training transcript with the following dementia related topics and hours: -September 28, 2021, Communication and	01540		

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01540	Continued From page 33 people with dementia-one hour -September 28, 2021, Dementia Care: Understanding Alzheimer's Disease-1/2 hour -December 9, 2021, Care of Residents with Dementia in AL (assisted living)-3/4 hour -December 9, 2021, Alzheimer's Disease and Related Disorders: Behavior and ADL (activities of daily living) Management-one hour ULP-G's record indicated a total of 3.25 hours of dementia related training and lacked the required eight hours of dementia training within 80 hours of employment. Additionally, ULP-G's record lacked the minimum requirement of two hours of annual dementia training. On August 10, 2023, at 11:30 a.m. housing coordinator (HC)-K stated she was relatively new to the role of managing employee training and was still learning the Relias training topics and how they related to the required topics. HC-K stated she could not speak to ULP-K's dementia training as it was coordinated by someone else. HC-K confirmed ULP-G's Relias transcript reflected 3.25 hours of dementia training at time of orientation and the required two hours of dementia training, annually. The licensee's Assisted Living with Dementia Care-Dementia Training policy dated July 2023, indicated Assisted living staff would receive required training on dementia care during orientation and annually. b. Direct-care employees will I. complete a minimum of eight hours of initial training on dementia care topics II. initial training will be completed within 80 working hours of the employment start date. Dementia care training would include:	01540		

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01540	Continued From page 34 I. An explanation of Alzheimer's disease and other dementias II. Assistance with activities of daily living III. Problem solving with challenging behaviors IV. Communication skills V. Person-centered planning and service delivery VI. Understanding cognitive impairment, VII. Understanding behavioral and psychological symptoms of dementia VIII. Standards of dementia care including nonpharmacological dementia care practices that are person-centered and evidence-informed No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01750		

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01750	Continued From page 35 review, the licensee failed to ensure two of two unlicensed personnel (ULP-E, ULP-G) completed insulin administration via a prefilled insulin pen according to manufacturer instructions. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 R1's diagnoses included diabetes (the body's inability to adequately manage blood sugar), and chronic kidney disease. R1's Service Plan dated January 31, 2023, indicated R1 received services to include medication management and blood sugar checks. R1's provider orders dated December 12, 2022, indicated Novolin N FlexPen 100 units/milliliter (units/ml) subcutaneous (injected into the skin) once daily at 7:00 a.m., with instructions to include, have client dial up 30 units and inject subcutaneously one time a day in the morning. (Roll the insulin pen in your hands until mixed together. The insulin should look cloudy). On August 8, 2023, at 7:20 a.m. ULP-E was observed to remove R1's Novolog insulin FlexPen from the locked medication box in R1's apartment. ULP-E checked the electronic	01750		

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01750	Continued From page 36 Medication Record (eMAR) on her tablet to confirm the insulin dosage, removed the FlexPen tip and placed a new needle to the tip (without wiping the FlexPen tip first). ULP-E handed the FlexPen to R1 who then dialed the FlexPen to the designated dose of 30 units, showed it to ULP-E and self-injected into her lower left abdomen and held in place for about six seconds. ULP-E did not first prime the FlexPen with the designated two units of insulin, nor did she direct R1 to do so prior to dialing the 30 units and injecting the insulin. On August 8, 2023, at 7:30 a.m. ULP-E stated she was not aware she needed to wipe the FlexPen tip prior to placing a new needle, or to prime the insulin FlexPen to ensure air was removed and the proper dose of insulin was administered. R2 R2's diagnoses included dementia and diabetes. R2's Service plan dated June 15, 2023, indicated R2 received services to include medication management and blood sugar checks. R2's provider orders dated June 19, 2023, indicated Novolog injection FlexPen inject 12 units subcutaneously three times daily after meals. Do not give if blood glucose is less than 90 or (R2) ate less than 25% of his meal. On August 8, 2023, at 9:15 a.m. ULP-G was observed to check R2's eMAR on his tablet, removed the Novolog insulin FlexPen from R2's locked medication drawer, removed the FlexPen tip and placed a new needle to the FlexPen (without first wiping the FlexPen tip). ULP-G set the FlexPen to the designated dose of 12 units of	01750		

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01750	Continued From page 37 insulin, exposed R2's lower abdomen and without cleansing the skin with an alcohol wipe, injected the insulin into the lower left abdomen and withdrew the FlexPen immediately after the injection. ULP-G failed to wipe the insulin pen tip prior to attaching a new needle, failed to prime the needle with the required two units of Novolog insulin, failed to cleanse the skin with alcohol and failed to hold the insulin pen in place for the designated six seconds during administration. On August 8, 2023, at 9:20 a.m. ULP-G stated he was not aware he needed to wipe the FlexPen tip with alcohol, prime the insulin FlexPen, or hold in place for six seconds following injection. He stated he was trained and competencied by a registered nurse in 2021, but could not recall that nurse's name. On August 8, 2023, at 1:45 p.m. clinical nurse supervisor (CNS)-C stated the proper steps as taught and confirmed with staff competency included wiping the tip of the insulin pen with alcohol prior to placing a new needle, and then priming the insulin pen with two units of insulin prior to injection, and ensure staff held the FlexPen in place for an additional six seconds. The licensee's Injection Medication Administration Competency/Procedure for Insulin Pens dated May 23, 2023, included the steps to: remove the (insulin) pen cap and clean with an alcohol wipe, connect the needle to the pen, and prime the pen per manufacturer's instructions; to remove any air bubbles that may be present. Dial the dose of insulin to be given on the pen. Verify the dose against the order, and clean the injection site with alcohol wipe or soap and water before injecting the insulin, gently depress the plunger on the syringe and hold the needle in place at the	01750		

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01750	Continued From page 38 injection site for five to six seconds before removing. Novolog manufacturer's instructions dated February 2023, indicated for the user to remove the flex pen cap and wipe the flex pen tip with an alcohol wipe prior to placing a new needle on the flex pen tip, prime the FlexPen with two units of insulin, cleanse the skin prior to injection and hold the FlexPen in place for the count of six following injection. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two	01760		

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	30563	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ESTATES	815 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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01760	Continued From page 39 unlicensed personnel (ULP)-G) provided the proper dose of a topical medication. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2's diagnoses included dementia and diabetes. R2's Service plan dated June 15, 2023, indicated R2 received services to include medication management. R2's provider orders dated June 19, 2023, indicated Diclofenac 1% gel (a topical pain reliever), 2 grams (gm) apply to painful areas (joints or back) four times daily. On August 8, 2023, at 8:10 a.m. ULP-G was observed to complete medication administration, he referenced the eMAR on his tablet, administered 12 oral medications, one nasal spray and applied diclofenac 1% gel to R2's lower back. ULP-G stated he could not find the measuring tool to accurately measure the two grams of diclofenac gel, but "just squirted some on his gloved hand and applied it where it was needed". ULP-G failed to accurately measure the quantity (dose) of R2's Diclofenac gel. On August 8, 2023, at 1:45 p.m. clinical nurse	01760		

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01760	Continued From page 40 supervisor (CNS)-C stated she would ensure R2's diclofenac gel had the proper measuring tool available to the ULP for accurate dosing. CNS-C stated each box contained a measuring tool, but it often was thrown away. The licensee's Topical Medication Administration Competency/Procedure for Topical medications dated May 23, 2023, indicated staff would check RTasks (the licensee's electronic medical record) for the appropriate order and instructions for administration. Additionally, before, during and after medication administration, check the six rights of medication administration (included the right dose). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were kept in the original container bearing the original prescription label for one of two residents (R1).	01890		

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01890	Continued From page 41 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: R1's diagnoses included diabetes (when the body cannot regulate blood sugar) and chronic kidney disease. R1's signed Service Plan dated January 31, 2023, indicated R1 received the services of medication set up by the registered nurse (RN) and medication administration. R1's signed physician's orders dated December 2, 2022, included Novolin Flex-pen 100 units/milliliter (u/ml), have client dial 30 units and inject subcutaneously (into the skin), once daily at 7:00 a.m., and lidocaine patch 5%, apply one patch to the lower back in the morning. On August 8, 2023, at 7:00 a.m. unlicensed personnel (ULP)-E was observed to open the locked medication box in R1's apartment. ULP-E counted, verified via the electronic medication administration record (eMAR) found on her tablet, and administered nine oral medications from a pill box. The pill box had previously been set up by the registered nurse. ULP-E also obtained a topical (on the skin) lidocaine 5% patch from a set of six patches within the locked medication box. The lidocaine patches lacked a proper label. ULP-E also obtained an unlabeled Novolog	01890		

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01890	Continued From page 42 insulin pen, prepped the pen by removing the cap, attached a new needle and handed the pen to R1 who then dialed the appropriate dose of 30 units and self-administered to her abdomen. The Novolog insulin pen and lidocaine patch lacked a proper label to indicate the resident's name, prescription number, directions for use, and name/address of the licensed pharmacy that issued the pen. On August 8, 2023, at 1:45 p.m. clinical nurse supervisor (CNS)-C stated she set up medications for the resident's locked boxes in the assisted living area and had not thought about providing proper labels when medications were split from their original packaging which did have a proper label. The licensee's Storage of Medications policy dated August 2023, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01910	Continued From page 43	01910		
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 licensee failed to document in the resident's record the disposition of the medication including the required content for one of one discharged resident (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) 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).	01910		

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01910	Continued From page 44 The findings include: R4's record indicated he began receiving services on April 1, 2022, and was discharged to the nursing home also on campus on June 27, 2023. R4's Nurse's note dated June 27, 2023, at 11:06 a.m. indicated resident discharged to (nursing home name) on June 27, 2023. Medications sent with resident at time of discharge. Discharge packet printed and sent with resident. R4's Medication Administration Record (MAR) dated June 1, 2023, through June 27, 2023, included aspirin (mild pain/heart medication), Benazepril (blood pressure), capsaicin cream (pain ointment), metformin (oral diabetic medication), metoprolol (heart rate/blood pressure medication), rosuvastatin (cholesterol), and spironolactone (blood pressure). R4's record lacked a medication disposition at the time of his discharge. On August 8, 2023, at 1:00 p.m. clinical nurse supervisor (CNS)-C reviewed R4's record and stated she had not completed a disposition of medications at the time of R4's discharge to the nursing home. The licensee's Disposition or Disposal of Medication policy dated August 2023, indicated staff would document in the resident's record the name of the person to whom them medications were given, the time and date, the name of each medication, and the amount remaining. No further information was provided.	01910		

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01910	Continued From page 45 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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 the observation, document review, and interview, the licensee failed to develop a memory care site-specific safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	02040		

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02040	Continued From page 46 a large portion or all of the clients). The findings include: On August 8, 2023, approximately from 10:30 a.m. to 12:15 p.m., survey staff toured with the maintenance director (MD)-I. On August 8, 2023, at approximately 12:30 p.m., a documentation review and interview were performed with the MD-I relating to the memory care site-specific safety risk/vulnerability assessment and mitigation plan, indicating the licensee had not yet developed a memory care site-specific safety risk assessment and mitigation plan to identify vulnerabilities and mitigations on and around the property to protect the memory care residents from harm. The findings were confirmed during the interview with the MD-I that the licensee lacked the memory care site-specific provisions. On August 8, 2023, at approximately 1:15 p.m., at the exit interview, the MD-I and the licensed assisted living director-B verified and acknowledged the above findings. Survey staff discussed the findings and explained that all potential safety risks and/or vulnerabilities site-specific to memory care residents on and around the property including the common kitchenette areas, elopement risks from windows and powered door deactivation, and any other potential risks need to be identified, assessed, and mitigated and be documented in the plan to protect the memory care residents from harm. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced	02110		

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02110	Continued From page 48 by: Based on interview and record review, the licensee failed to ensure policies and procedures required in assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for three of three residents (R1, R2, R3). 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: The licensee was licensed as an Assisted Living with Dementia Care facility on May 1, 2023. R1, R2, and R3's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects	02110		

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02110	Continued From page 49 of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On August 8, 2023, at 2:20 p.m. licensed assisted living director (LALD)-B stated she was not aware of the requirement and verified the inclusive list of dementia care policies had not been provided to each resident and/or representative as required. The licensee's Assisted living with Dementia Care-Notification to Resident Representative policy dated July 2023, noted the necessary policies and information related to dementia care would be provided to the residents' representatives upon admission to the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
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	03000		

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03000	Continued From page 50 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 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,	03000		

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03000	Continued From page 51 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) for a significant set of medication errors for one of one resident (R5). 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 service plan dated March 27, 2023, indicated she received services to include medication administration. The licensee's Medication Error reports dated July 13, 2023, at 10:14 a.m. indicated four medication errors in five days: -Dates of medication errors-July 7, 2023, July 8, 2023, July 10, 2023, and July 11, 2023. -Medications involved-warfarin 3 milligrams (mg). -Description of error-medication charted as given but pills still in medication card. -Reason for the medication error-failure to verify correct resident/medication/time/route. -Was the medical provider	03000		

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SPRING VALLEY ESTATES	815 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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
03000	Continued From page 52 contacted-Yes-anticoagulation clinic -If "yes", what was the response of the MD- give 4 mg warfarin tonight (July 13, 2023) and keep appointment to recheck International Normalized Ratio (INR)-a blood clotting test used to measure how quickly blood forms a clot) tomorrow (July 14, 2023). -Actions taken to prevent future errors-Education will be provided to all staff. Change made to ensure verification process for all pills separately verses [vs] charting in the dosage box. The licensee's Medication Error reports dated July 18, 2023, at 1:24 p.m. indicated two additional medication errors involving warfarin: -Dates of medication errors-July 15, 2023, and July 16, 2023. -Medication involved-warfarin 3 mg. -Description of medication errors-not given to tenant [resident]. Medication was still in the punch card. -Was the medical provider contacted-Yes-anticoagulation clinic -If "yes" what was the response of the MD-anticoagulation clinic notified and advised to make changes to rest of week doses -Actions taken to ensure the well-being of the resident-Changed times to 4:00 p.m. so is the only medication given at that time and advised staff to call nurse when administering. The licensee failed to report the series of significant medication errors to MAARC. On August 9, 2023, at 11:40 a.m. clinical nurse supervisor (CNS)-C stated she had looked into the pattern of errors with R5's warfarin and found with the first set of missed doses (July 7, 8, 10, 11, 2023), a system upgrade with rTasks (the licensee's electronic medical record system)	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30563	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ESTATES	815 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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
03000	Continued From page 53 caused a glitch in the eMAR which identified a "virtual mediset" in which the unlicensed personnel (ULP) did not recognize the need to administer the warfarin. Even though the warfarin was in R5's medication box, it was not questioned. CNS-C stated they had corrected this glitch in the system. With the second set of missed doses (July 15, 2023, and July 16, 2023), the same ULP missed the warfarin administration and was not certain why the doses were missed. CNS-C stated as an effort to mitigate future errors, she moved R5's warfarin from 8:00 p.m. to 4:00 p.m. so it was the only medication given and the ULP were to notify nursing when the warfarin was given. CNS-C stated she made the proper calls to the anticoagulation clinic to report the errors, and to family. She stated R5's INR had been subtherapeutic (out of the intended range to prevent blood clots) since her admission on March 27, 2023. The medication errors created additional warfarin dose adjustments and additional lab work/trips to the clinic in Rochester were required. CNS-C stated she had not considered filing a MAARC report as she didn't feel this was a case of abuse but had not thought of neglect. The licensee's Vulnerable Adult Maltreatment Policy dated February 8, 2023, indicated the organization would create an environment and process to identify, prevent, and mitigate maltreatment of vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Environmental Health - FPLS

Rochester

Type: Full
Date: *08/07/23*
Time: 10:32:53
Report: 1038231533

Food and Beverage Establishment Inspection Report

Location:
Spring Valley Estates
815 Memorial Drive
Spring Valley, MN55975
Fillmore County, 23

Establishment Info:
ID #: 0037519
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073461241
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO ONE ON STAFF, MANAGER IS IN TRAINING
Comply By: 08/07/23

Surface and Equipment Sanitizers

Hot Water: = at 185 Degrees Fahrenheit
Location: Hot Water Dishwasher
Violation Issued: No

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Sanitizing bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: Cole slaw
Violation Issued: No

Process/Item: Hot Holding
Temperature: 189 Degrees Fahrenheit - Location: Spagettii Sauce
Violation Issued: No

Process/Item: Hot Holding
Temperature: 196 Degrees Fahrenheit - Location: Veg Meddly
Violation Issued: No

Type: Full
Date: *08/07/23*
Time: 10:32:53
Report: 1038231533
Spring Valley Estates

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: Onion
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: 0 Degrees Fahrenheit - Location: Frozen Corn
Violation Issued: No

Process/Item: Cooking
Temperature: 185 Degrees Fahrenheit - Location: Hamburgers
Violation Issued: No

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

dietary@springvalleyliving.org

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 1038231533 of 08/07/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Establishment Representative

Signed:_____
Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us