Electronically Delivered

November 8, 2024

Licensee
Whispering Oak Place
903 Calverly Court
Ellendale, MN 56026

RE: Project Number(s) SL30599015

Dear Licensee:

On October 8, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 24, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Electronically Delivered

August 16, 2024

Licensee
Whispering Oak Place
903 Calverly Court
Ellendale, MN 56026

RE: Project Number(s) SL30599015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 24, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30599	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING OAK PLACE	903 CALVERLY COURT ELLENDALE, MN 56026

(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: SL30599015-0 On July 22, 2024, through July 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 28 resident(s); 25 receiving services under the provider's Assisted Living Facility 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 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 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 evaluators ' 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 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting the licensee's residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a licensee's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470		

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0 470	Continued From page 2 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a capacity of 48 residents, with a current census of 28 residents. On July 22, 2024, at 1:15 p.m. during a facility tour, the licensee's staffing plan was posted on a bulletin board in a common area with other required postings. The staffing plan was dated June 28, 2023, and was signed by licensed assisted living director (LALD)-A. On July 22, 2024, at 3:08 p.m. LALD-A stated the staffing plan was last updated in June 2023, as indicated, and was not aware the staffing plan was required to be reviewed and updated twice yearly by the registered nurse (RN). The licensee's registered nurse (RN) failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. The licensee's Staffing and Scheduling-Minnesota policy dated January 31, 2024, indicated the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week.	0 470		

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0 470	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control during treatments and medication administration for one of three unlicensed personnel (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 510		

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0 510	Continued From page 4 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F began providing services under the Assisted Living license on April 19, 2024. On July 22, 2024, ULP-F was observed completing the following: - At 4:15 p.m., ULP-F entered R9's room, used hand sanitizer and put on gloves. ULP-F administered eye drops to R9. ULP-F then requested R9 go to the bathroom to empty her colostomy. R9 went to the bathroom and sat on the toilet with the colostomy bag hanging between her legs to drain into the toilet. ULP-F removed the clip which secured the end of the ostomy bag where the stool is drained out of. R9 then emptied the stool from the bag into the toilet. ULP-F then opened the end of the bag where the stool was emptied from, and poured some water into the bag. R9 swished the water around in the bag to rinse it and drained the contents into the toilet. ULP-F stated it needed to be rinsed some more, opened the end of the bag and poured more water in. R9 again swished the water around the bag and drained it. ULP-F then used the clip to secure the opening of the bag. ULP-F removed gloves and returned to the medication cart and used hand sanitizer. ULP-F failed to wash her hands with soap and water after they were visibly soiled with stool during the emptying of the colostomy. - At 4:27 p.m., ULP-F put on gloves, punched medications out of pill cards into a cup, went to R6's room and administered the medications. ULP-F did not remove gloves, use hand sanitizer, or wash hands. - At 4:45 p.m., ULP-F was still wearing the same	0 510		

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0 510	Continued From page 5 gloves, punched R10's medications out of pill cards into a cup, went to R10's room and administered the medications. ULP-F removed gloves and returned to the medication cart. - At 4:58 p.m., ULP-F used hand sanitizer and put on gloves. ULP-F punched medications into a medication cup, removed a blood glucose meter and an insulin pen from the med cart, and brought the items to R5's room. ULP-F administered the oral medications to R5, handed the blood glucose meter to R5 and R5 checked her blood sugar. ULP-F placed the strip and lancet into the sharps container. ULP-F then set up the insulin pen for R5 and handed the insulin pen to R5 to administer. ULP-F placed the used needle in the sharps container. ULP-F returned the blood glucose meter and insulin pen to the medication cart, removed her gloves, and used hand sanitizer. ULP-F failed to wash her hands. On July 23, 2024, at 11:02 a.m. clinical nurse supervisor (CNS)-B stated staff should wash their hands after they are visibly soiled. Staff can use hand sanitizer between residents; however, staff should wash their hands after emptying a colostomy bag and after completing blood glucose monitoring and insulin administration. The licensee's 2.17 Hand Washing policy dated January 15, 2024, identified: "Hand Hygiene is cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel. Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers. Antiseptic soaps and detergents are the next most effective and non-antimicrobial soaps are	0 510		

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0 510	Continued From page 6 the least effective. When hands are not visibly dirty, alcohol-based hand sanitizers are the preferred method for cleaning your hands in the healthcare setting. Soap and water are recommended for cleaning visibly dirty hands." "When to Perform Hand Hygiene - Before eating - Before and after performing personal cares - After contact with blood, body fluids or excretions, mucous membranes, non-intact skin - If hands will be moving from a contaminated body site to a clean body site during patient care - After glove removal - After handling soiled items - Before handling medication - Before handling resident food - Before handling catheters - Between dirty and clean procedures" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including	0 650		

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0 650	Continued From page 7 qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E started employment on December 6, 2023, to provide direct care services to the licensee's residents. On July 22, 2024, at 2:12 p.m. ULP-E was observed to administer medications to several residents in the memory care unit. ULP-E's employee file lacked evidence of the	0 650		

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0 650	Continued From page 8 required orientation training topics to include: -overview of Assisted Living statutes, -handling of resident complaints; -consumer advocacy services; -review of types of Assisted Living services the employee will provide and provider's scope of license; and -principles of person-centered planning/service delivery On July 24, 2024, at 10:45 a.m. licensed assisted living director (LALD)-A stated she had provided the required training listed above on January 5, 2024, which was the same day the registered nurse completed the medical related training. LALD-A stated she did not at that time, have a way to document the specific orientation training topics. She reached out to the licensee's corporate team and was later able to obtain the designated form to complete for employees' orientation training and has since used that. LALD-A stated she had forgotten to go back to ULP-E's file to update the training record with the form. The licensee's Employee Records policy dated May 6, 2022, indicated the employee records for each person would include records of all training and in-service education required and/or provided including record of competency testing as required and records of all training and in-service education required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 800	Continued From page 9	0 800		
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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on July 23, 2024, with maintenance coordinator (MC)-H, between 10:00 a.m. and 1:15 p.m. the following facility hazards and disrepair were observed: FIRE DOORS:	0 800		

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0 800	Continued From page 10 The surveyor observed several fire doors that were propped open, had the pins removed from hinges or had a various devices holding them open, including the kitchen door and an opening in the kitchen wall to the dining area/corridor. All doors to the corridors or stairwells shall close and latch under their own power. Several resident room doors were propped open. The surveyor explained to MC-H, that all doors to the corridor must meet the state statute for fire doors and the fire rating shall be always maintained. EMERGENCY/EXIT LIGHTS: The surveyor observed some of the exit/emergency lights failed to operate when push button tested by MC-H. The surveyor explained to MC-H that all emergency/exit lights shall operate when push button tested, be push button tested monthly, the 30-minute test completed annually, documented and shall comply with the Minnesota State Fire Code. BUIDLING MAINTENANCE: The surveyor observed the gypsum board above the shower in resident room 210 needed repair/patch/paint. There had been some water damage in the area at some point. MC-H stated he is working on fixing this. The surveyor observed the bathroom exhaust fan in resident room 210 did not operate. The surveyor explained to MC-H that the exhaust	0 800		

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0 800	Continued From page 11 fan shall be repaired. The deficient conditions were visually verified by MC-H accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly 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	0 820		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING OAK PLACE	903 CALVERLY COURT ELLENDALE, MN 56026

(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
0 820	Continued From page 12 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: During the facility tour on July 23, 2024, with maintenance coordinator (MC)-H, between 10:00 a.m. and 1:15 p.m. the following facility hazards and disrepair were observed: MAGNETIC DOOR LOCKS: The surveyor observed the 2nd floor north and south stairwell exit doors, main front exit door and the back exit door from the dining room area had an exit sign posted above them and these doors were designated as emergency exits on the posted evacuation map. There was a magnetic lock on the interior side of the doors that required entry of a code into a keypad beside the door to exit. Some of these areas were used for dementia care residents in the past but are not presently. The surveyor explained to MC-H that all exit doors shall open from the inside with one motion and no special knowledge and shall comply with the Minnesota State Fire Code. The deficient conditions were visually verified by MC-H accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		

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01060	Continued From page 13	01060		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060		

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01060	Continued From page 14 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content, to the resident, legal representative, and designated representative, for an emergency relocation for one of one resident (R1). In addition, the licensee failed to notify the Office of Ombudsman for Long-Term Care of the relocation within four days as required. 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 progress notes identified on December 22, 2023, R1 was sent to the emergency room and was hospitalized. On December 28, 2024, R1 was still in the hospital receiving therapy. On January 5, 2024, it was noted R1 resided in a skilled nursing facility for rehabilitation. R1's discharge summary dated January 31, 2024, indicated R1 needed assist of two staff and a mechanical lift for transfers and the decision had been made to discharge her to a skilled nursing	01060		

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01060	Continued From page 15 facility for ongoing care. R1's record failed to identify the resident and the resident's representative had been provided, as soon as practicable, a written notice that contained, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. R1's record also failed to notify the Office of Ombudsman for Long-Term Care of the relocation within four days. On July 22, 2024, at 5:15 p.m. clinical nurse supervisor (CNS)-B stated the resident had been sent in after hours by the triage nurse and the facility's clinical nurse supervisor at the time should have completed the required emergency transfer paperwork and notification on their next scheduled day to work. R1's lacked evidence this had been completed. The licensee's undated, Notification of Emergency Relocation Form indicated the following: -the reason for the relocation;	01060		

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01060	Continued From page 16 -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. The form indicated the form would be provided to the resident, resident representative, and case manager; in addition, if the resident was out of the facility for longer than four days the ombudsman would be provided the form. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01540 SS=F	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	01540		

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01540	Continued From page 17 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; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed the required amount of dementia care training in the required time frame for two of two employees (unlicensed personnel (ULP)-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The licensee had an assisted living with dementia care license dated April 28, 2024. ULP-E ULP-E had a hire date of December 6, 2023. ULP-E's employee file included a Relias (the licensee's designated online training program) training transcript printed July 24, 2024, included a total of 5.25 hours of dementia training. On July 24, 2024, at 12:24 p.m. licensed assisted	01540		

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01540	Continued From page 18 living director (LALD)-A stated ULP-E was hired as an on-call employee and had worked a total of 194 hours to date. ULP-F ULP-F had a hire date of April 19, 2024. ULP-F's employee file included a Relias training transcript printed July 24, 2024, and included a total of 6.25 hours of dementia training. On July 24, 2024, at 12:24 p.m. LALD-A stated ULP-F had worked a total of 474 hours to date. On July 24, 2024, at 12:40 p.m. LALD-A stated both employees had worked the above listed number of hours and stated they did not have the required eight hours of dementia related training. LALD-A stated she understood the requirement was seven hours of dementia training and was following the set of dementia training topics and hours provided to her by the licensee's corporate office. LALD-A stated there was always another staff onsite working who had the required number of dementia training hours if needed for support. The licensee's Dementia training policy dated January 31, 2024, indicated Assisted Living with Dementia Care licensed facilities direct care employees will complete eight hours of initial training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		

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01620	Continued From page 19	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a comprehensive assessment every 90 days for one of three residents (R5). In addition, the licensee failed to complete a smoking assessment 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	01620		

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01620	Continued From page 20 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 22, 2024, ULP-F was observed administering medications to R5. ULP-F stated R5 was a smoker and she goes outside the front doors of the facility to smoke. R5's medical record included the following: - Comprehensive assessment dated November 25, 2023; - Comprehensive assessment dated March 5, 2024, there was 102 days between assessments; - Comprehensive assessment dated April 2, 2024; and - Comprehensive assessment dated June 27, 2024. All the comprehensive assessments identified smoking with a response of "smoking assessment is not applicable". On July 23, 2024, at 10:27 a.m. clinical nurse supervisor (CNS)-B stated R5 was a smoker and the smoking assessment should have been completed. On July 23, 2024, at 11:02 a.m. CNS-B stated R5's assessments should have been completed at least every 90 days. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated December 28, 2023, identified "Resident reassessment and monitoring must be conducted no more than 14 calendar	01620		

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01620	Continued From page 21 days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional	01730		

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01730	Continued From page 22 when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the accurate content for one of three residents (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: On July 22, 2024, at 4:58 p.m. ULP-F unlocked the medications cart, removed R5's oral medications and set up medications into a medication cup for R5. ULP-F then removed a	01730		

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01730	Continued From page 23 blood glucose meter and an insulin pen from the med cart, and brought the items to R5's room. ULP-F administered the oral medications to R5 and handed the blood glucose meter to R5. R5 checked her blood sugar, and R5 reported her blood sugar to be 272. ULP-F placed a needle on the insulin pen and handed the pen to R5. ULP-F informed R5 the sliding scale dose was 8 units. R5 stated 8 units plus 30 units, so 38 units total. ULP-F confirmed the dose was 38 units. Neither ULP-F or R5 completed an air shot to prime the insulin pen. R5 dialed the insulin pen to 38 units and administered the insulin. R5's Individualized Medication Management Plan dated June 27, 2024, identified R5 received medication administration and included the following: - Medications were stored in residents apartment in locked cupboard/drawer; however, mediations were stored in a locked medication cart. - medication management tasks that may be delegated to unlicensed personnel included multiple routes of administration; however, it failed to include insulin administration. On June 23, 2024, at 10:27 a.m. clinical nurse supervisor (CNS)-B stated the Individualized Medication Management Plan was inaccurate and should have identified medication storage in the medication cart. Staff were trained for insulin administration and it should have been included under the delegated tasks in the medication plan. The licensee's 7.03 Medication Management Individualized Plan dated January 31, 2024, indicated the medication plan would include the following: - A description of storage of medications based on the resident's needs and preferences, risk of	01730		

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01730	Continued From page 24 diversion, and consistent with the manufacturer's directions - Identification of medication management tasks that may be delegated to unlicensed personnel No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01730		
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 medications were administered as ordered for the licensee's one resident (R5) receiving insulin administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01760		

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01760	Continued From page 25 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 22, 2024, at 4:58 p.m. ULP-F unlocked the medications cart, removed R5's oral medications and set up medications into a medication cup for R5. ULP-F then removed a blood glucose meter and a Fiasp insulin pen from the cart, and brought the items to R5's room. ULP-F administered the oral medications to R5 and handed the blood glucose meter to R5. R5 checked her blood sugar, and R5 reported her blood sugar to be 272. ULP-F placed a needle on the insulin pen and handed the pen to R5. ULP-F informed R5 the sliding scale dose was 8 units. R5 stated 8 units plus 30 units, so 38 units total. ULP-F verbally confirmed the dose was 38 units. Neither ULP-F or R5 completed an air shot to prime the insulin pen. R5 dialed the insulin pen to 38 units and administered the insulin. ULP-F failed to check the MAR or observe what the pen was actually dialed to. R5's July 2024, Medication Administration Record (MAR), included the following orders: - administer Fiasp 35 units insulin subcutaneously one time a day with evening meal. - In addition to Fiasp 35 units, add sliding scale insulin - 70-149 =0, - 150-199 =2 additional units, - 200-249 =4 additional units, - 250-299 =8 additional units, - 300-349 =14 additional units, - 350-399 =18 additional units,	01760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING OAK PLACE	903 CALVERLY COURT ELLENDALE, MN 56026

(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
01760	Continued From page 26 - 400-449 =20 additional units, - 450-500+ =22 additional units R5's MAR indicated Fiasp 35 units of insulin, and since the blood glucose was 272, an additional 8 units of insulin per sliding scale, for a total of 43 units of insulin should have been administered. However, only 38 units were administered. On July 23, 2024, at 10:27 a.m. clinical nurse supervisor (CNS)-B stated staff were trained to set up the insulin pen with the needle and staff were to prime the insulin pen prior to handing it to the resident to assure accurate dosing. The total dose of Fiasp R5 should have received was 43 units. Staff should have checked the MAR, verified the dose, and observed the pen dialed by R5 prior to R5 injecting the dose. Fiasp prescribing information dated July 2023, included the following steps: Priming your FIASP® FlexTouch® Pen: "Step 7: · Turn the dose selector to select 2 units Step 8: · Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top Step 9: · Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows "0". The "0" must line up with the dose pointer. · A drop of insulin should be seen at the needle tip. · If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times. · If you still do not see a drop of insulin, change the needle and repeat steps 7 to 9." No further information was provided.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30599	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING OAK PLACE	903 CALVERLY COURT ELLENDALE, MN 56026

(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
01760	Continued From page 27 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow delegated procedures for the licensee's one resident (R5) receiving insulin administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 22, 2024, at 4:58 p.m. ULP-F unlocked the medication cart, removed R5's oral medications and set up medications into a medication cup for R5. ULP-F then removed a blood glucose meter and a Fiasp insulin pen from	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30599	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING OAK PLACE	903 CALVERLY COURT ELLENDALE, MN 56026

(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
02320	Continued From page 28 the cart, and brought the items to R5's room. ULP-F administered the oral medications to R5 and handed the blood glucose meter to R5. R5 checked her blood sugar, and R5 reported her blood sugar to be 272. ULP-F placed a needle on the insulin pen and handed the pen to R5. ULP-F informed R5 the sliding scale dose was 8 units. R5 stated 8 units plus 30 units, so 38 units total. ULP-F verbally confirmed the dose was 38 units. Neither ULP-F or R5 completed an air shot to prime the insulin pen. R5 dialed the insulin pen to 38 units and administered the insulin. ULP-F failed to check the MAR or observe what the pen was actually dialed to. R5's July 2024, Medication Administration Record (MAR) included the following orders: - administer Fiasp 35 units insulin subcutaneously one time a day with evening meal. - In addition to Fiasp 35 units, add sliding scale insulin - 70-149 =0, - 150-199 =2 additional units, - 200-249 =4 additional units, - 250-299 =8 additional units, - 300-349 =14 additional units, - 350-399 =18 additional units, - 400-449 =20 additional units, - 450-500+ =22 additional units Although R5's MAR indicated Fiasp 35 units, and since the blood glucose was 272, add 8 additional units of sliding scale insulin for a total of 43 units should have been administered. However, only 38 units were administered. On July 23, 2024, at 10:27 a.m. clinical nurse supervisor (CNS)-B stated staff were trained to set up the insulin pen with the needle and staff were to prime the insulin pen prior to handing it to the resident to assure accurate dosing. The total	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30599	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 29 dose of Fiasp R5 should have received was 43 units. Staff should have checked the MAR, verified the dose, and observed the pen dialed by R5 prior to R5 injecting the dose. Fiasp prescribing information dated July 2023, included the following steps: Priming your FIASP® FlexTouch® Pen: "Step 7: · Turn the dose selector to select 2 units Step 8: · Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top Step 9: · Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows "0". The "0" must line up with the dose pointer. · A drop of insulin should be seen at the needle tip. · If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times. · If you still do not see a drop of insulin, change the needle and repeat steps 7 to 9." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health
Environmental Health - FPLS

Rochester

Type: Full
Date: *07/23/24*
Time: 15:35:39
Report: 1038241082

Food and Beverage Establishment Inspection Report

Location:
Whispering Oak Place
903 Calvery Court
Ellendale, MN56026
Steele County, 74

Establishment Info:
ID #: 0019973
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
PPRC, LLC

Phone #: 5076843026
ID #: 53288

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 190 Degrees Fahrenheit
Location: Hot Water
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Onion
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Cheese Slices
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Ice Cream
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Frozen Peas
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Sausage Crunbs
Violation Issued: No

Type: Full
Date: *07/23/24*
Time: 15:35:39
Report: 1038241082
Whispering Oak Place

Food and Beverage Establishment Inspection Report

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

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1038241082 of 07/23/24.

Certified Food Protection Manager: Shelly Smidt

Certification Number: FM1622 Expires: 05/14/27

Signed: _____
Establishment Representative

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