Electronically Delivered

April 25, 2025

Licensee
Ma's Room and Board
605 East Avenue
Red Wing, MN 55066

RE: Project Number(s) SL32641016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 1, 2025, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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 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: SL32641016-0 On March 31, 2025, through April 1, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 10 residents; 10 receiving services under the Assisted Living Facility 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.	
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license, effective August 1, 2024. The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the	0 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 420	Continued From page 2 provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on April 8, 2024. As a result of this survey, the following orders were issued under 0470, 0550, 0630, 0640, 0660, 0680, 0730, 1370, 1380, 1440, 1530, 1620, 1640, 1730, 1750, 1790, 1820, 1910, 1940, 1970, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 470	Continued From page 3 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 observation, interview, and record review, the licensee failed to ensure the required staffing plan was developed and posted as required, potentially affecting the licensee's current residents, staff, and any visitors of 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 a widespread scope (when	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 470	Continued From page 4 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 entrance conference on March 31, 2025, at approximately 9:00 a.m., the licensee's staffing plan was requested. On March 31, 2025, at approximately 9:30 a.m., licensed assisted living director (LALD)-A provided the surveyor a facility tour. The main entry and common areas were observed to include various required postings; however, there was no daily staffing schedule posted as required. On April 1, 2025, at 1:12 p.m., LALD-A stated the daily staffing schedule was not posted as required. General manager (GM)-C stated the staffing plan could not be located. The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor and failed to develop and implement a staffing plan for determining its staffing level that: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building; - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 470	Continued From page 5 unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 550	Continued From page 6 licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a 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: On March 31, 2025, at 9:30 a.m. during the facility tour with licensed assisted living director (LALD)-A, the surveyor observed the licensee's grievance procedure posted in the entrance. Although the posted grievance procedure included the contact information for the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Adult Abuse Reporting Center (MAARC), the posting did not include the name, telephone number and email contact information for individuals who were responsible for handling resident grievances. On April 1, 2025, at 1:10 p.m., LALD-A reviewed the posted grievance procedure and stated it did not include the name, telephone number, and email contact for the individuals who were responsible for handling resident grievances. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1 and R2). 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 was admitted on March 4, 2021, with diagnoses that included diabetes and dementia.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 630	Continued From page 8 R1's service plan dated August 1, 2022, indicated R1 received services to include bathing, hygiene/grooming assistance, medication set up, insulin injections and medication administration. On April 1, 2025, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R1. R1's IAPP dated February 1, 2025, indicated R1 was not susceptible to abuse from another individual, including other vulnerable adults. The licensee failed to recognize R1 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize his abuse by others including other vulnerable adults. R2 R2 was admitted on January 14, 2022, with diagnosis that included diabetes and anxiety. R2's service plan dated July 1, 2023, indicated R2 received services to include bathing, hygiene/grooming assistance, medication set up and medication administration. On April 1, 2025, at 8:24 a.m., the surveyor observed ULP-F administer medications to R2. R2's IAPP dated February 1, 2025, indicated R2 was not susceptible to abuse from another individual, including other vulnerable adults. The licensee failed to recognize R2 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize R2's abuse by others including other vulnerable adults. On March 31, 2025, at 1:48 p.m., clinical nurse	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 630	Continued From page 9 supervisor (CNS)-B stated R1 and R2 were considered vulnerable adults and their IAPP should have indicated they were at risk to be abused. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, indicated all residents in an assisted living area are categorically considered vulnerable adults and the license would develop and implement an individual abuse prevention plan for each vulnerable adult. 1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. Other vulnerable adults b. The person's risk of abusing other vulnerable adults, and c. Statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults 2. for purposes of the abuse prevention plan, abuse includes self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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;	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 640	Continued From page 10 (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 and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) 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: The licensee failed to post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On March 31, 2025, at 9:30 a.m., the surveyor observed the entry and common areas within the facility and noted there was no posting of the information and reporting number for MAARC, as required. On April 1, 2025, at 1:11 p.m., licensed assisted	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 640	Continued From page 11 living director (LALD)-A stated the MAARC information was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) to include a facility tuberculosis (TB) risk assessment. This practice resulted in a level two violation (a	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 660	Continued From page 12 violation that did no 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: On March 31, 2025, at approximately 9:00 a.m., the surveyor requested the licensee's TB risk assessment. The licensee provided a Facility TB Risk assessment dated October 25, 2021. On March 31, 2025, at 10:19 a.m., licensed assisted living director (LALD)-A stated they could not locate an updated TB Risk assessment. The licensee's Tuberculosis Screening policy dated November 12, 2022, indicated the facility would maintain a current community TB risk assessment. The assessment would be updated annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 680	Continued From page 13 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an emergency disaster plan prominently, have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. 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:	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 680	Continued From page 14 EMERGENCY PLAN POSTED On March 31, 2025, at approximately 9:30 a.m. during the facility tour, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted. Licensed assisted living director (LALD)-A stated the plan was not posted prominently. LALD-A stated the plan was kept in a binder in the staff office that was locked and not accessible to residents or visitors when staff were out of the office. EMERGENCY PREPAREDNESS PLAN (EPP) CONTENT The licensee's Emergency Preparedness plan dated January 22, 2024, was reviewed and lacked the following: - establish and maintain a comprehensive EPP, reviewed/updated annually; - identification of at-risk population needs like maintaining independence, communication, transportation, supervision, medical care; and qualified person authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies; - policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal; - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 680	Continued From page 15 relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing safe evacuation form facility, including care and treatment needs of evacuees; staff responsibilities; primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure addressing use of volunteers, including the process/role for integration; - policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - develop a written communication plan; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional, and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional, and local emergency management agencies; - communication plan which includes method for	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 680	Continued From page 16 sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and - communication plan which includes method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives. On April 1, 2025, at 1:16 p.m., LALD-A stated the EP plan did not include the required content as listed above. LALD-A further stated the licensee was working with an outside agency to review and update the EP plan. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, indicated the licensee's emergency preparedness plan would include all required elements of Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 730	Continued From page 17 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 730	Continued From page 18 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included the required documentation of all provided services for two of two residents (R1 and R2). The licensee also failed to include the required content in a discharge summary for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: DOCUMENTATION OF SERVICES PROVIDED: R1 R1 was admitted on March 4, 2021, with diagnoses that included diabetes and dementia. R1's service plan dated August 1, 2022, indicated R1 received services to include bathing, hygiene/grooming assistance, medication set up, insulin injections and medication administration. The service plan did not include blood glucose	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 730	Continued From page 19 checks, oxygen management, daily vital signs or weight management services. R1's record lacked documentation of the following services provided: -bathing -hygiene/grooming -oxygen management R2 R2 was admitted on January 14, 2022, with diagnosis that included diabetes and anxiety. R2's service plan dated July 1, 2023, indicated R2 received services to include bathing, hygiene/grooming assistance, medication set up and medication administration. The service plan did not include blood glucose checks, vital signs, weight monitoring or CPAP (continuous positive airway pressure- a machine that helps keep the airways open during sleep) services. R2's record lacked documentation of the following services provided: -bathing -hygiene/grooming -CPAP assistance On April 1, 2025, at 11:05 a.m., licensed assisted living director (LALD)-A stated R1 and R2's record lacked documentation of the services provided as listed above. The licensee's Resident Record-Documentation policy dated August 1, 2021, indicated staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to the resident.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 730	Continued From page 20 DISCHARGE SUMMARY R3 R3 was admitted to the licensee on May 2, 2017, and discharged to another facility on April 2, 2024. R3's record lacked a discharge summary to include the following required content: -a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, treatments and therapies and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On April 1, 2025, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated R3's record lacked a discharge summary with the required content as listed above. CNS-B stated the same discharge summary document was used for all residents upon discharge. The licensee's Resident Discharge Summary form dated June 2021, indicated the discharge	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 730	Continued From page 21 summary would include the following: -a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results -a final summary of the resident's status from the latest assessment or review, if applicable, which includes the resident status, including baseline and current mental, behavioral, and functional status -a reconciliation of all pre-discharge medications with the resident's post-discharge prescribed and over-the-counter medications -a post-discharge care plan that is developed with the resident and, with the resident's consent, the resident's representative, which will help the resident adjust to a new living environment. The post-discharge care plan will indicate where the resident plans to reside, any post-discharge medical and nonmedical services the resident will need. The discharge summary is provided to the resident, and, with the resident's consent, the resident's representatives and case manager. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility;	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01370	Continued From page 22 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-E and ULP-F) to include all required content.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01370	Continued From page 23 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 ULP-E was hired on January 24, 2025, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of competency evaluation for the following topics: -appropriate and safe techniques in personal hygiene and grooming including: -bathing -care and use of hearing aids ULP-F ULP-F was hired on June 28, 2023, to provide direct care and services to the facility's residents. ULP-F's employee record lacked evidence of competency evaluation for the following topics: -appropriate and safe techniques in personal hygiene and grooming including -care and use of hearing aids -standby assistance techniques and how to perform them On April 1, 2025, at 10:35 a.m., clinical nurse supervisor (CNS)-B stated ULP-E and ULP-F were trained and competent in all areas listed above; however, ULP-E and ULP-F's record lacked evidence of the competency evaluations.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01370	Continued From page 24 The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations for all ULPs would include: -Appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -standby assistance techniques and how to perform them No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01380	Continued From page 25 required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-E and ULP-F) to include all required content. 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 ULP-E was hired on January 24, 2025, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of competency evaluation for the following topics: -reading and recording respirations of the resident; -safe transfer techniques and ambulation; -range of motion and positioning ULP-F ULP-F was hired on June 28, 2023, to provide direct care and services to the facility's residents. ULP-F's employee record lacked evidence of competency evaluation for the following topics: -reading and recording respirations of the	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01380	Continued From page 26 resident; -safe transfer techniques and ambulation; -range of motion and positioning On April 1, 2025, at 10:35 a.m., clinical nurse supervisor (CNS)-B stated ULP-E and ULP-F were trained and competent in all areas listed above; however, ULP-E and ULP-F's record lacked evidence of the competency evaluations. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations for all ULPs would include: -reading and recording temperature, pulse, and respirations of the resident -safe transfer techniques and ambulation -range of motioning and positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	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	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01440	Continued From page 27 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 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 staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for two of two 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, 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 the potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E was hired on January 24, 2025, to provide direct care and services to the facility's residents. On March 31, 2025, at 10:27 a.m., the surveyor observed ULP-E administer medications to R4.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01440	Continued From page 28 ULP-F ULP-F was hired on June 28, 2023, to provide direct care and services to the facility's residents. On April 1, 2025, at 8:12 a.m., the surveyor observed ULP-F administer medications to R1. ULP-E and ULP-F's employee records lacked documentation of a registered nurse (RN) supervising ULP-E and ULP-F performing a delegated task within 30 days of beginning work with the licensee. On April 1, 2025, at 10:38 a.m., clinical nurse supervisor (CNS)-B stated the house manager (HM) would check in with the ULP after 30 days to discuss their performance; however, would not observe the ULP performing delegated tasks as the HM was not a nurse. CNS-B stated all ULP's records lacked a 30-day supervision of delegated tasks by the RN. The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated 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 licensee and first performs the delegated task for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01530	Continued From page 29 (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E) received the required amount of dementia care training in 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	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01530	Continued From page 30 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 provided services under an Assisted Living Facility license. ULP-E was hired on January 24, 2025, to provide direct care and services to the facility's residents. ULP-E's employee record contained evidence the employee received four and a half hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. On April 1, 2025, at 10:42 a.m., licensed assisted living director (LALD)-A stated ULP-E had not completed the required eight hours of initial dementia care training. LALD-A stated ULP-E was employed full time and had worked more than 160 hours since the start of her employment. The licensee's Dementia Training policy dated August 1, 2021, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01620	Continued From page 31 (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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted timely ongoing nursing assessments for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01620	Continued From page 32 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on March 4, 2021, with diagnoses that included diabetes and dementia. R1's service plan dated August 1, 2022, indicated R1 received services to include bathing, hygiene/grooming assistance, medication set up, insulin injections and medication administration. R1's assessments dated August 1, 2024, November 1, 2024, and February 1, 2025, were reviewed. The November 1, 2024, assessment was completed 92 days after the date of the previous assessment, thus exceeding 90 calendar days. The February 1, 2025, assessment was completed 92 days after the date of the previous assessment, thus exceeding 90 calendar days. R2 R2 was admitted on January 14, 2022, with diagnosis that included diabetes and anxiety. R2's service plan dated July 1, 2023, indicated R2 received services to include bathing, hygiene/grooming assistance, medication set up and medication administration. R2's assessments dated August 1, 2024, November 1, 2024, and February 1, 2025, were reviewed. The November 1, 2024, assessment was completed 92 days after the date of the previous	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01620	Continued From page 33 assessment, thus exceeding 90 calendar days. The February 1, 2025, assessment was completed 92 days after the date of the previous assessment, thus exceeding 90 calendar days. On March 31, 2025, at 1:47 p.m., clinical nurse supervisor (CNS)-B stated R1 and R2's assessments were not completed within the required time frame. The licensee's Assessments, Reviews and Monitoring policy dated August 11, 2022, indicated resident reassessment and monitoring must be conducted o 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01640	Continued From page 34 and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on March 4, 2021, with diagnoses that included diabetes and dementia. On April 1, 2025, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-F check R1's weight. ULP-F also supervised R1 check his	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01640	Continued From page 35 own blood glucose. R1's service plan dated August 1, 2022, indicated R1 received services to include bathing, hygiene/grooming assistance, medication set up, insulin injections and medication administration. The service plan did not include blood glucose checks, oxygen management, daily vital signs or weight management services. R1's medication administration record (MAR) dated March 2025, indicated the staff assisted R1 with the following services: -Oxygen 3 liters nightly; staff double check that it is set at 3 liters, and he has it on at bedtime -Blood Glucose checks twice daily -Vitals; record vital signs as directed daily -Weight/Height; record weight and height daily R2 R2 was admitted on January 14, 2022, with diagnosis that included diabetes and anxiety. On April 1, 2025, at 8:24 a.m., the surveyor observed ULP-F supervise R2 check his blood glucose. R2's service plan dated July 1, 2023, indicated R2 received services to include bathing, hygiene/grooming assistance, medication set up and medication administration. The service plan did not include blood glucose checks, vital signs, weight monitoring or CPAP (continuous positive airway pressure (machine helps keep the airways open during sleep) services. R2's MAR dated March 2025, indicated the staff assisted R2 with the following services: -Blood Glucose checks twice daily -CPAP	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01640	Continued From page 36 -Vitals; Record Vital signs as directed once a week -Weight/Height; record weight and height weekly On April 1, 2025, at 10:48 a.m., clinical nurse supervisor (CNS)-B stated R1 and R2's service plan did not include the services as listed above. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include a description of the services that are to be provided based on the most recent assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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;	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01730	Continued From page 37 (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 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 required content for one of two residents (R2). 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).	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01730	Continued From page 38 The findings include: During the entrance conference on March 31, 2025, at approximately 9:00 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. R2 was admitted on January 14, 2022, with diagnosis that included diabetes and anxiety. On April 1, 2025, at 8:24 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R2. R2's service plan dated July 1, 2023, indicated R2 received services to include medication set up and medication administration. R2's medication administration record (MAR) dated March 2025, included the following medication: -epinephrine 0.2 milligrams (mg); give injection as needed for allergic reaction -albuterol inhaler 90 micrograms (mcg); take two puffs for shortness of breath or wheezing every four hours as needed-resident keeps on him. R2's record lacked signed prescriber orders for epinephrine and albuterol inhaler. R2's Individualized Medication Management Plan dated August 1, 2024, indicated R2's medications were administered by staff and R2's medications were stored in a locked medication room. On April 1, 2025, at 11:13 a.m., clinical nurse supervisor (CNS)-B stated R2 carried the epinephrine pen with him and would self-inject if	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01730	Continued From page 39 needed after being stung by a bee. CNS-B stated R2 also kept his albuterol inhaler in his room. CNS-B reviewed R2's individualized medication management plan and stated it did not include self-storage or self-administration for the epinephrine pen and albuterol inhaler. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, noted the RN would develop and maintain a current individualized medication management record for each resident based on the resident's assessment. The medication management record will be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=E	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:	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01750	Continued From page 40 Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for two of two residents (R1 and R2) whose medication administration was delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on March 4, 2021, with diagnoses that included diabetes, dementia and chronic obstructive pulmonary disease (COPD). On April 1, 2025, at 8:12 a.m., the surveyor observed ULP-F administer medications to R1. R1's service plan dated August 1, 2022, indicated R1 received services to include medication set up and medication administration. R1's medication administration record (MAR) dated March 2025, included the following medications: -Glucose 4 milligrams (mg); give one tablet for low blood sugar The licensee failed to have resident-specific instructions regarding what blood sugar result	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01750	Continued From page 41 was considered a low blood sugar and would indicate administering glucose to R1. R2 R2 was admitted on January 14, 2022, with diagnosis that included diabetes and anxiety. On April 1, 2025, at 8:24 a.m., the surveyor observed ULP-F administer medications to R2. R2's service plan dated July 1, 2023, indicated R2 received services to include medication set up and medication administration. R2's record lacked current prescriber orders for the following medication orders: -acetaminophen 500 mg; take two tablets up to three times a day every 6-8 hours (pain) -albuterol 2.5 mg/2 milliliter (ml) solution; inhale 3 ml by nebulizer every six hours as needed for wheezing or shortness of breath -albuterol 90 microgram (mcg) inhaler; take two puffs for shortness of breath or wheezing every four hours -diabetic safe tussin DM 10 mg; take two teaspoons every four hours as needed (not more than six doses in 24 hours) (cough) -guaifenesin 600 mg; take one tablet by mouth two times per day as needed for cough -hydrocortisone cream 1%; apply to affected area up to three times a day (skin rash) -triamcinolone acetonide cream; apply small amount to affected areas (skin rash) -TUMS; take 1-2 tablets as needed (heartburn) ACETAMINOPHEN: R2's MAR dated March 2025, included the following medication: -acetaminophen 500 mg; take two tablets up to three times a day every 6-8 hours (pain)	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01750	Continued From page 42 The licensee failed to have resident-specific instructions regarding whether to give acetaminophen every six hours versus every eight hours. ALBUTEROL: R2's MAR dated March 2025, included the following medications: -albuterol 2.5 mg/2 ml solution; inhale 3 ml by nebulizer every six hours as needed for wheezing or shortness of breath -albuterol 90 mcg inhaler; take two puffs for shortness of breath or wheezing every four hours The licensee failed to provide instructions for the ULP to understand which PRN medication for shortness of breath and wheezing should be used in which order. COUGH MEDICINE: R2's MAR dated March 2025, included the following medications: -diabetic safe tussin DM 10 mg; take two teaspoons every four hours as needed (not more than six doses in 24 hours) (cough) -guaifenesin 600 mg; take one tablet by mouth two times per day as needed for cough The licensee failed to provide instructions for the ULP to understand which PRN medication for cough should be used in which order. TOPICAL CREAMS: R2's MAR dated March 2025, included the following medications: -hydrocortisone cream 1%; apply to affected area up to three times a day (skin rash) -triamcinolone acetonide cream; apply small amount to affected areas (skin rash)	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01750	Continued From page 43 The licensee failed to provide instructions for the ULP to understand which PRN medication for skin rash should be used in which order. TUMS: R2's MAR dated March 2025, included the following order: -TUMS; take 1-2 tablets as needed (heartburn) The licensee failed to have resident-specific instructions regarding whether to give one or two tablets and the frequency to administer TUMS. On April 1, 2025, at 11:22 a.m., clinical nurse supervisor (CNS)-B stated there were no written instructions regarding R1 and R2's medications as listed above. The licensee's Medication and Treatment Orders policy dated August 1, 2021, indicated an order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01790	Continued From page 44 the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01790	Continued From page 45 (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for one of two unlicensed personnel (ULP-F) providing medications to residents for unplanned time away from home when the licensed nurse was not available. 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-F was hired on June 28, 2023, to provide direct care and services to the facility's residents.	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01790	Continued From page 46 ULP-F's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On April 1, 2025, at 10:37 a.m., clinical nurse supervisor (CNS)-B stated ULP-F was trained, and competency tested on providing medications to residents for unplanned time away, but did not have documentation of the training or competencies. The licensee's Medication Management-Planned and Unplanned Time Away policy dated August 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: 1. The registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01820	Continued From page 47 written or electronically recorded prescriptions were obtained for all medications the provider managed for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on March 4, 2021, with diagnoses that included diabetes, dementia and chronic obstructive pulmonary disease (COPD). On April 1, 2025, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R1. R1's service plan dated August 1, 2022, indicated R1 received services to include medication set up and medication administration. R1's medication administration record (MAR) dated March 2025, included the following medications: -acetaminophen 500 milligram (mg); take two tablets three times a day (pain) -arthritis pain relief 0.075% cream; apply small amount to lower back four times a day (pain) -aspirin 81 mg; take one tablet every morning (cardiac health) -atorvastatin 20 mg; take one tablet every night at	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01820	Continued From page 48 bedtime (cholesterol) -carvedilol 12.5 mg; take one tablet two times a day (blood pressure) -fluoxetine 10 mg; give one capsule every morning (depression) -gabapentin 300 mg; take two tablets in the morning (nerve pain) -gabapentin 300 mg; take one tablet at 2:00 p.m., and 8:00 p.m. (nerve pain) -Incruse Ellipta 62.5 microgram (mcg) inhaler; inhale one puff daily (COPD) -Jardiance 25 mg; take one tablet every morning before breakfast (blood thinner) -lisinopril 20 mg; take one tablet by mouth once a day (blood pressure), prescriber order dated February 25, 2025. -metformin 500 mg; take three tablets at 12:00 p.m. (diabetes) -nortriptyline 50 mg; take one tablet at bedtime (depression) -Tresiba Flextouch pen 100 units/milliliter (ml); Give 20 units every morning (diabetes) -Trulicity 1.5 mg/0.5 ml pen; inject 1.5 mg every Wednesday (diabetes) -Debrox 6.5% ear drops; five drops in both ears as needed (ear wax) -diabetic Tussin; give 10 ml as needed every four hours as needed (cough) -Glucose 4 mg; give one tablet for low blood sugar -lorazepam 0.5 mg; give one tablet for complaints of pressure in the chest or anxiety if all vitals are within normal limits two times a day, eight hours apart. -nitroglycerin 0.4 mg; place one tablet under tongue every five minutes until pain subsides (chest pain) -Ventolin 90 mcg inhaler; inhale one puff every four hours as needed (COPD)	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01820	Continued From page 49 R1's record lacked signed prescriber orders for the following medications: -acetaminophen 500 mg; take two tablets three times a day (pain) -arthritis pain relief 0.075% cream; apply small amount to lower back four times a day (pain) -aspirin 81 mg; take one tablet every morning (cardiac health) -atorvastatin 20 mg; take one tablet every night at bedtime (cholesterol) -carvedilol 12.5 mg; take one tablet two times a day (blood pressure) -fluoxetine 10 mg; give one capsule every morning (depression) -gabapentin 300 mg; take two tablets in the morning (nerve pain) -gabapentin 300 mg; take one tablet at 2:00 p.m., and 8:00 p.m. (nerve pain) -Incruse Ellipta 62.5 mcg inhaler; inhale one puff daily (COPD) -Jardiance 25 mg; take one tablet every morning before breakfast (blood thinner) -metformin 500 mg; take three tablets at 12:00 p.m. (diabetes) -nortriptyline 50 mg; take one tablet at bedtime (depression) -Tresiba Flextouch pen 100 units/ml; Give 20 units every morning (diabetes) -Trulicity 1.5 mg/0.5 ml pen; inject 1.5 mg every Wednesday (diabetes) -Debrox 6.5% ear drops; five drops in both ears as needed (ear wax) -diabetic Tussin; give 10 ml as needed every four hours as needed (cough) -Glucose 4 mg; give one tablet for low blood sugar -lorazepam 0.5 mg; give one tablet for complaints of pressure in the chest or anxiety if all vitals are within normal limits two times a day, eight hours apart.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01820	Continued From page 50 -nitroglycerin 0.4 mg; place one tablet under tongue every five minutes until pain subsides (chest pain) -Ventolin 90 mcg inhaler; inhale one puff every four hours as needed (COPD) R2 R2 was admitted on January 14, 2022, with diagnosis that included diabetes and anxiety. On April 1, 2025, at 8:24 a.m., the surveyor observed ULP-F administer medications to R2. R2's service plan dated July 1, 2023, indicated R2 received services to include medication set up and medication administration. R2's MAR dated March 2025, included the following medications: -aripiprazole 2 mg; take one tablet daily (depression) -cetirizine 10 mg; take one tablet by mouth daily, (allergies) prescriber order dated February 17, 2025. -Emgality Pen 120 mg; One injection at 120 mg every 30 days (migraines) -Dry Eye Relief; one drop in each eye four times a day (dry eyes) -finasteride 5 mg; take one tablet by mouth daily (prostate) -fluocinolone 0.01%; apply small amount on affected areas two times a day (skin irritation) -fluticasone propionate nasal spray; two sprays into each nostril daily (allergies) -gabapentin 300 mg; three capsules three times a day (nerve pain) -hydrochlorothiazide 25 mg; take one tablet one time daily (diuretic) -ketoconazole 2% shampoo, shampoo three times weekly	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01820	Continued From page 51 -Lipitor 40 mg; take one tablet every night at bedtime (cholesterol) -melatonin 3 mg; take one tablet by mouth at bedtime (sleep) -metformin 1,000 mg; take one tablet two times a day with meals (diabetes) -miralax 17 grams (g); mix 17 g with full glass of water (constipation) -omeprazole 40 mg; take one capsule before breakfast and supper (heartburn) -Ozempic 4 mg/3 ml; Inject 1 mg once a week (diabetes), prescriber order dated January 6, 2025. -prazosin 1 mg; take one capsule every night at bedtime along with 2 mg capsule for a nightly 3 mg (blood pressure) -prazosin 2 mg; take one capsule at bedtime (blood pressure) -propranolol 80 mg; take one capsule daily (blood pressure) -Pulmicort flexhaler 180 mcg/actuation; inhale two puffs twice a day (asthma) -Sennosides-docusate sodium; give one tablet twice daily (constipation) -venlafaxine 150 mg; take two capsules one time a day (anxiety) -acetaminophen 500 mg; take two tablets up to three times a day every 6-8 hours (pain) -albuterol 2.5 mg/2 ml solution; inhale 3 ml by nebulizer every six hours as needed for wheezing or shortness of breath -albuterol 90 mcg inhaler; take two puffs for shortness of breath or wheezing every four hours -diabetic safe tussin DM 10 mg; take two teaspoons every four hours as needed (not more than six doses in 24 hours) (cough) -epinephrine 0.3 mg; give injection as needed for allergic reaction -guaifenesin 600 mg; take one tablet by mouth two times per day as needed for cough	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01820	Continued From page 52 -hydrocortisone cream 1%; apply to affected area up to three times a day (skin rash) -ondansetron 8 mg; take one tablet every eight hours as needed for nausea -polyethylene glycol; give 17 grams with full glass of water for constipation -triamcinolone acetonide cream; apply small amount to affected areas (skin rash) -TUMS; take 1-2 tablets as needed (heartburn) R2's record lacked prescriber orders for the following medications: -aripiprazole 2 mg; take one tablet daily (depression) -cetirizine 10 mg; take one tablet by mouth daily, (allergies) prescriber order dated February 17, 2025. -Emgality Pen 120 mg; One injection at 120 mg every 30 days (migraines) -Dry Eye Relief; one drop in each eye four times a day (dry eyes) -finasteride 5 mg; take one tablet by mouth daily (prostate) -fluocinolone 0.01%; apply small amount on affected areas two times a day (skin irritation) -fluticasone propionate nasal spray; two sprays into each nostril daily (allergies) -gabapentin 300 mg; three capsules three times a day (nerve pain) -hydrochlorothiazide 25 mg; take one tablet one time daily (diuretic) -ketoconazole 2% shampoo, shampoo three times weekly -Lipitor 40 mg; take one tablet every night at bedtime (cholesterol) -melatonin 3 mg; take one tablet by mouth at bedtime (sleep) -metformin 1,000 mg; take one tablet two times a day with meals (diabetes) -miralax 17 g; mix 17 g with full glass of water	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01820	Continued From page 53 (constipation) -omeprazole 40 mg; take one capsule before breakfast and supper (heartburn) -prazosin 1 mg; take one capsule every night at bedtime along with 2 mg capsule for a nightly 3 mg (blood pressure) -prazosin 2 mg; take one capsule at bedtime (blood pressure) -propranolol 80 mg; take one capsule daily (blood pressure) -Pulmicort flexhaler 180 mcg/actuation; inhale two puffs twice a day (asthma) -Sennosides-docusate sodium; give one tablet twice daily (constipation) -venlafaxine 150 mg; take two capsules one time a day (anxiety) -acetaminophen 500 mg; take two tablets up to three times a day every 6-8 hours (pain) -albuterol 2.5 mg/2 ml solution; inhale 3 ml by nebulizer every six hours as needed for wheezing or shortness of breath -albuterol 90 mcg inhaler; take two puffs for shortness of breath or wheezing every four hours -diabetic safe tussin DM 10 mg; take two teaspoons every four hours as needed (not more than six doses in 24 hours) (cough) -epinephrine 0.3 mg; give injection as needed for allergic reaction -guaifenesin 600 mg; take one tablet by mouth two times per day as needed for cough -hydrocortisone cream 1%; apply to affected area up to three times a day (skin rash) -ondansetron 8 mg; take one tablet every eight hours as needed for nausea -polyethylene glycol; give 17 grams with full glass of water for constipation -triamcinolone acetonide cream; apply small amount to affected areas (skin rash) -TUMS; take 1-2 tablets as needed (heartburn)	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01820	Continued From page 54 On April 1, 2025, at 11:21 a.m., clinical nurse supervisor (CNS)-B stated R1 and R2's record lacked signed prescriber orders as listed above. General manager (GM)-C stated the licensee would send a "Doctor Appointment Sheet" with to every medical appointment. GM-C stated a copy of the resident's medications would be attached to the Doctor Appointment Sheet for the provider to review and sign that the medication list was accurate. GM-C stated R1 and R2 were both seen by their primary care provider on March 10, 2025, where the provider signed the doctor appointment sheet indicating that the attached medication list was accurate. However, GM-C stated to reduce the number of documents in the resident's medical charts the licensee had removed the attached medication list from all the doctor appointment sheets and discarded them. The licensee's Medication and Treatment Orders policy dated August 1, 2021, indicated a current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01910	Continued From page 55 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 prescription numbers as applicable, and to whom the medications were given for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3 was admitted to the licensee on May 2, 2017, and discharged on April 2, 2024. R3's Disposition of Meds form dated April 2,	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01910	Continued From page 56 2024, had two columns that identified the medication and quantity, a signature line for the facility nurse. The document did not include a column for the medication strength, or prescription number as applicable. On March 31, 2025, at 1:33 p.m., clinical nurse supervisor (CNS)-B stated the facility's medication disposal form used for all residents did not include the required content as listed above. The licensee's Resident Record-Documentation policy dated August 1, 2021, indicated the license was authorized to document in a resident record will do so for all medications, services, treatments and therapies for each resident. Staff will also document other important and pertinent information relating to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01940	Continued From page 57 provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01940	Continued From page 58 R1 R1 was admitted on March 4, 2021, with diagnoses that included diabetes and dementia. On April 1, 2025, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-F check R1's weight. ULP-F also supervised R1 check his blood glucose R1's service plan dated August 1, 2022, indicated R1 received services to include bathing, hygiene/grooming assistance, medication set up, insulin injections and medication administration. The service plan did not include blood glucose checks, oxygen management, daily vital signs or weight management services. R1's medication administration record (MAR) dated March 2025, indicated the staff assisted R1 with the following treatments: -Oxygen 3 liters nightly; staff double check that it is set at 3 liters, and he has it on at bedtime -Blood Glucose checks twice daily -Vitals; record vital signs as directed daily -Weight/Height; record weight and height daily R1's record lacked prescriber orders for blood glucose checks, daily vital signs, daily weights and oxygen. R1's Individualized Treatment or Therapy Management Plan dated August 1, 2024, failed to include the following required content: -documentation of specific resident instructions relating to the treatments or therapy administration -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01940	Continued From page 59 appropriate licensed health professional when a problem arises with treatment or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R1's Individualized Treatment Plan indicated the above areas were addressed on R1's MAR, however, the MAR did not include required content as listed above. R2 R2 was admitted on January 14, 2022, with diagnosis that included diabetes and anxiety. On April 1, 2025, at 8:24 a.m., the surveyor observed ULP-F supervise R2 check his blood glucose. R2's service plan dated July 1, 2023, indicated R2 received services to include bathing, hygiene/grooming assistance, medication set up and medication administration. The service plan did not include blood glucose checks, vital signs, weight monitoring or CPAP (continuous positive airway pressure- a machine that helps keep the airways open during sleep) services. R2's MAR dated March 2025, indicated the staff assisted R2 with the following treatments: -Blood Glucose checks twice daily -CPAP Filter; change CPAP filter -Vitals; record vital signs as directed every week -Weight/Height; record weight and height every week	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01940	Continued From page 60 R2's record lacked prescriber orders for blood glucose checks, CPAP, weekly vital signs and weekly weights. R2's Individualized Treatment or Therapy Management Plan dated August 1, 2024, did not include the following required content: -documentation of specific resident instructions relating to the treatments or therapy administration -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R2's Individualized Treatment Plan indicated the above areas were addressed on R1's MAR; however, the MAR did not include the required content as listed above. On April 1, 2025, at 11:05 a.m., clinical nurse supervisor (CNS)-B stated R1 and R2's individualized treatment plan lacked the required content as noted above. The licensee's Treatment and Therapy Management Plan policy dated August 2, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -documentation of specific resident instructions	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01940	Continued From page 61 relating to the treatments or therapy administration -identification of treatment or therapy tasks that will be delegated to unlicensed personnel -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services -any resident-specific requirements relating to documentation of treatment and therapy received -verification that all treatment and therapy was administered as prescribed -monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of two residents (R1 ad R2) receiving treatments.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01970	Continued From page 62 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on March 4, 2021, with diagnoses that included diabetes and dementia. On April 1, 2025, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-F check R1's weight. ULP-F also supervised R1 check his own blood glucose R1's service plan dated August 1, 2022, indicated R1 received services to include bathing, hygiene/grooming assistance, medication set up, insulin injections and medication administration. The service plan did not include blood glucose checks, oxygen management, daily vital signs or weight management services. R1's medication administration record (MAR) dated March 2025, indicated the staff assisted R1 with the following treatments: -Oxygen 3 liters nightly; staff double check that it is set at 3 liters, and he has it on at bedtime -Blood Glucose checks twice daily -Vitals; record vital signs as directed daily -Weight/Height; record weight and height daily	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01970	Continued From page 63 R1's record lacked prescriber orders for blood glucose checks, daily vital signs, daily weights and oxygen. R2 R2 was admitted on January 14, 2022, with diagnosis that included diabetes and anxiety. On April 1, 2025, at 8:24 a.m., the surveyor observed ULP-F supervise R2 check his own blood glucose. R2's service plan dated July 1, 2023, indicated R2 received services to include bathing, hygiene/grooming assistance, medication set up and medication administration. The service plan did not include blood glucose checks, vital signs, weight monitoring or CPAP (continuous positive airway pressure- a machine that helps keep the airways open during sleep) services. R2's MAR dated March 2025, indicated the staff assisted R2 with the following treatments: -Blood Glucose checks twice daily -CPAP Filter; change CPAP filter -Vitals; record vital signs as directed every week -Weight/Height; record weight and height every week R2's record lacked prescriber orders for blood glucose checks, CPAP, weekly vital signs and weekly weights. On April 1, 2025, at 11:05 a.m., clinical nurse supervisor (CNS)-B stated R1 and R2's record lacked prescriber orders for treatments as listed above. The licensee's Medication and Treatment Orders policy dated August 1, 2021, indicated a current,	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
01970	Continued From page 64 authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Food, Pools, Lodging
3425 40th Ave NW
Rochester
507-206-2721

Type: Full
Date: *03/31/25*
Time: 14:38:44
Report: 8074251045

Food and Beverage Establishment Inspection Report

Location:
Ma'S Room And Board
605 East Avenue
Red Wing, MN55066
Goodhue County, 25

Establishment Info:
ID #: 0038934
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513989709
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.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

No thin stem thermometer for food.

Comply By: 04/01/25

Surface and Equipment Sanitizers

Hot Water: = at 172 Degrees Fahrenheit
Location: internal dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: yogurt
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: ambient (milk)
Violation Issued: No

Type: Full
Date: *03/31/25*
Time: 14:38:44
Report: 8074251045
Ma'S Room And Board

Food and Beverage Establishment Inspection Report

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

Discussed kick plate in kitchen is becoming worn.

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 8074251045 of 03/31/25.

Certified Food Protection Manager: Sherri Vanberg

Certification Number: FM49738 Expires: 04/07/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Andrea Kieffer

Rochester District Office