Electronically Delivered

May 5, 2023

Licensee
The Meadows of Wadena
110 Hemlock Avenue Northwest
Wadena, MN 56482

RE: Project Number(s) SL33310015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 26, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions 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 the MDH within 15 calendar days of the correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

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

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,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33310	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF WADENA	110 HEMLOCK AVENUE NW WADENA, MN 56482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#33310015 On April 24, 2023, through April 26, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 38 active residents; 32 receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 24, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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	0 640		

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0 640	Continued From page 2 common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in the commons area to include posting the 911 emergency number, and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 24, 2023, at 11:30 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, and observed the main entrance and/or common areas lacked the required posting for the 911 emergency number and contact information for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557.	0 640		

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0 640	Continued From page 3 On April 24, 2022, at 12:05 p.m., LALD/CNS-A stated the 911 emergency number and the contact information for MAARC was not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 25, 2023, at 7:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A), stated the licensee's emergency plan book was a work in progress, and copies of the emergency preparedness plan (EPP) could be found in the LALD/CNS office, medication room in unsecured unit, secured unit, kitchen area, and maintenance office. However, the emergency plan was not posted prominently in commons areas. The licensee's undated EPP, lacked the following content and/or policies and procedures to address: - a completed hazard vulnerability assessment (HVA) to identify the most probable emergency situations that may be experienced by the facility or community; - have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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0 680	Continued From page 5 elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; - post an emergency disaster plan prominently; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - the facility's role in providing care and treatment at alternative sites; - the provision of subsistence needs for staff and residents; - a tracking system used to document locations of residents and staff; - the medical record documentation system the facility has developed to preserve resident information security and availability of records; and - EP training and testing program. In addition, the licensee lacked a communication plan, as part of the EPP, that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to include information about their occupancy; and - a method of sharing information from the emergency plan with residents and their families. On April 25, 2023, at 2:49 p.m., LALD/CNS-A stated the EPP lacked required content and was not posted prominently in commons areas.	0 680		

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0 680	Continued From page 6 The licensee's Emergency & Disaster Preparedness policy dated August 1, 2021, noted the facility would be prepared to manage emergency and disaster situations, including missing residents through the hazard assessment and emergency planning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services;	0 730		

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0 730	Continued From page 7 (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of one resident (R4) discharged from 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) 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:	0 730		

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0 730	Continued From page 8 The licensee's Discharge Resident/Client Roster dated October 24, 2022, to April 24, 2023, indicated R4 was admitted on August 4, 2022, and was discharged on December 30, 2022. R4's diagnoses included diabetes, hypertension (high blood pressure), arthritis, iron deficiency, and congested heart failure (CHF- a condition in which the heart's function as a pump is inadequate to meet the body's needs). R4's service plan dated August 5, 2022, indicated R4 received the following services: medication management, safety checks, housekeeping, laundry, and assistance with bathing. R4's Note dated December 8, 2022, indicated R4 would not be will [sic] enough to return to the facility. R4's financial power of attorney (POA) would be giving up R4's apartment and the apartment would be cleaned out by December 31, 2022. R4's record lacked a discharge summary. On April 24, 2023, at 2:40 p.m., registered nurse (RN)-B stated the discharge summary was usually completed within five days of the resident's discharge. RN-B stated R4 did not have a discharge summary and it must have been overlooked. The licensee's Discharge Summary policy dated August 1, 2021, noted the facility would document a summary of the resident's assisted living stay. The discharge summary would include, if applicable: a summary of the resident's stay; reconciliation of pre-discharge medications; and a post-discharge plan.	0 730		

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0 730	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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0 810	Continued From page 10 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, 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). Findings include: A record review and interview were conducted on April 26, 2023, at approximately 11:45 a.m. with Licensed Assisted Living Director/Clinical Nurse Specialist (LALD/CNS)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute.	0 810		

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0 810	Continued From page 11 Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the only drills were not conducted every other month and failed to provide two drills on second shift and two drills on third shift . During interview, LALD/CNS-A verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060		

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01060	Continued From page 12 (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	01060		

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	33310	A. BUILDING: _____ B. WING _____	04/26/2023

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01060	Continued From page 13 of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's Discharge Resident/Client Roster dated October 24, 2022, to April 24, 2023, indicated R4 was admitted on August 4, 2022, and was discharged on December 30, 2022. R4's diagnoses included diabetes, hypertension (high blood pressure), arthritis, iron deficiency, and congested heart failure (CHF- a condition in which the heart's function as a pump is inadequate to meet the body's needs). R4's service plan dated August 5, 2022, indicated R4 received the following services: medication management, safety checks, housekeeping, laundry, and assistance with bathing. R4's Notes included the following: - September 13, 2022, at 9:53 a.m., transferred to [name of a nearby hospital] for evaluation. - September 14, 2022, at 11:22 a.m., spoke with a nurse from [name of nearby long-term care facility]. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A explained to nurse that for R4 to return to the assisted living facility he would need to be able to complete his own blood sugar checks as well as his own insulin injections that need to be done with a pen, not drawn up. - November 8, 2022, at 9:48 a.m., LALD/CNS-A received a call from a social worker at [name of nearby long-term care facility] for an update on R4 yesterday. Social worker stated R4 was taken from the long-term care facility on Friday and was being transported to Fargo for an infection. - December 8, 2022, at 3:59 p.m., LALD/CNS-A	01060		

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01060	Continued From page 14 spoke with R4's financial power of attorney (POA). R4's POA stated R4 was not will [sic] enough to return to the facility. R4's POA would be giving up R4's apartment and the apartment would be cleaned out by December 31, 2022. R4's record lacked a discharge summary. R4's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R4's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On April 24, 2023, at 2:46 p.m., LALD/CNS-A stated she had misinterpreted the emergency relocation regulation. LALD/CNS-A stated the facility had an emergency relocation notification form; however, this had not been completed for R4, nor had the OOLTC been notified when R4 had not returned to the facility within four days.	01060		

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01060	Continued From page 15 The licensee's Contract Termination policy dated August 1, 2021, noted the facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: the reason for the relocation; the name and contact information for the location to which the resident has been relocated and any new service provider; and contact information for the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility;	01650		

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01650	Continued From page 16 (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of three residents (R1, 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) 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 to the facility on June 14, 2019, under the comprehensive home care license, and began receiving services under the assisted living license on August 1, 2021. R1's diagnoses included dementia, hypertension (high blood pressure), and anxiety.	01650		

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01650	Continued From page 17 R1's service plan dated August 3, 2021, indicated the resident received the following services: medication administration, behavior management, laundry, housekeeping, and assistance with toileting, dressing, and bathing. R2 R2 was admitted to the facility December 19, 2019, under the comprehensive home care license, and began receiving services under the assisted living license on August 1, 2021. R2's diagnoses included congestive heart failure (weakened heart condition), hypertension (high blood pressure), and hyperlipidemia (high blood cholesterol). R2's service plan dated Agist 1, 2021, indicated the resident received the following services: medication management, oxygen assistance, laundry, housekeeping, and assistance with dressing and bathing. R1 and R2's service plans lacked the following required content: - the schedule and methods of monitoring assessments of residents; - the schedule and methods of monitoring staff providing the services; and - the action to be taken if the scheduled service cannot be provided. On April 25, 2023, at 4:02 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1 and R2's service plans had not been updated to reflect the required content noted above. The licensee's Contents of Service Plans policy	01650		

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01650	Continued From page 18 dated August 1, 2021, noted all assisted living residents would have an up-to-date service plan. The service plans would include the following: - schedule and methods of monitoring assessments; - schedule and methods of monitoring staff providing services; and - contingency plan which included the action taken if the scheduled service cannot be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the delegated nursing task of medication	01750		

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01750	Continued From page 19 administration, for three of three ULPs (ULP-C, ULP-D, ULP-E). This practice in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on April 6, 2023, to provide direct care services including medication administration to residents of the assisted living facility. On April 24, 2023, at 12:30 p.m., ULP-C stated her new employee training consisted of online training which she was still working on completing. ULP-C stated she shadowed another ULP for a couple of days and once she felt comfortable, she administered medications under the supervision of another ULP. ULP-C stated last Friday (April 21, 2023) she was "tested out" on medication administration by RN-B. ULP-C stated she had not been trained by the RN or demonstrated competency by the RN prior to administering medications under the supervision of another ULP. ULP-C's Skills Competency Test-Administration of Oral Medications dated April 21, 2023, indicated administration of oral medications skills/competency test was demonstrated and observed by RN-B.	01750		

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01750	Continued From page 20 ULP-D ULP-D was hired on March 15, 2023, to provide direct care services including medication administration to residents of the assisted living facility. On April 24, 2023, at 3:53 p.m., ULP-D stated her new employee training consisted of shadowing another ULP. ULP-D stated by the end of the first week of training she administered medications and provided cares to the residents under the supervision of another ULP. ULP-D stated on about day eight of her training LPN-G and RN-B did her competency testing for medication administration. ULP-D stated she had not been trained by the RN or demonstrated competency by the RN prior to administering medications under the supervision of another ULP. ULP-D's Skills Competency Test-Administration of Oral Medications dated April 5, 2023, indicated administration of oral medications skills/competency test was demonstrated and observed by licensed practical nurse (LPN)-G and RN-B. ULP-E ULP-E was hired on December 5, 2022, to provide direct care services including medication administration to residents of the assisted living facility. On April 25, 2023, at 7:05 a.m., ULP-E stated her new employee training consisted of shadowing another ULP. ULP-E stated by the end of the first week of training she administered medications and provided cares to the residents under the supervision of another ULP. ULP-E stated on about day seven of her training she was "tested out" on medication administration by RN-B.	01750		

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01750	Continued From page 21 ULP-E stated she had not been trained by the RN or demonstrated competency by the RN prior to administering medications under the supervision of another ULP. On April 25, 2023, at 11:48 a.m., the surveyor observed ULP-E prepare and administer the following medications to R2: furosemide 20 milligram (mg), Januvia 25 mg, and Potassium 10 milliequivalents (meq) (3 tabs). ULP-D's Skills Competency Test-Administration of Oral Medications dated December 21, 2022, indicated administration of oral medications skills/competency test was demonstrated and observed by RN-B. On April 25, 2023, at 2:37 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the ULP's do computer training, shadow with another ULP for six days, gradually performing delegated tasks, then a four-hour competency test out is completed with the RN or LPN. The LPN will observe a ULP competency for medication pass on evening and weekend, and the RN does another test out, on the same day if possible. The licensee's Delegation of Nursing Tasks, dated August 1, 2021, noted the CNS or RN may delegate medication administration to the ULP only after the CNS or RN has verified the ULP is educated and trained in the proper methods to administer the medications, and the ULP has demonstrated the ability to competently follow the procedures. TIME PERIOD FOR CORRECTION: Two (2) days	01750		

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01880	Continued From page 22	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for one of one nurse office/medication room. In addition, the licensee failed to ensure one of one medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: SECURITY OF MEDICATIONS On April 24, 2023, at 10:23 a.m., the surveyor observed the door to the nurse office to be propped open with a door stop and the attached medication room door to be open. The surveyor observed on the desk in the nurse office (which was in direct view of the main hallway) an	01880		

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01880	Continued From page 23 uncovered opened cardboard packing box. From the hallway one could visualize the box was filled with medication blister packs (a transparent, molded piece of plastic, often sealed to a sheet of cardboard, used to pack tablets). The cardboard box contained several medication blister packs for the following residents R1, R7, R8, R9, R10, R11 and R12. In addition, sitting on the counter in the open medication room was a bin of medication for an unknown resident. The nurse office/medication room were not being monitored by any staff members at this time. At 10:27 a.m., registered nurse (RN)-B entered the nurse office/medication room and closed the medication room door. RN-B stated the medications on the desk were the medications which had been delivered by pharmacy. RN-B stated both the main nurse office and medication room door should be closed and locked when unattended by staff. RN-B stated she forgot to close and lock the nurse office door when she left. STORAGE OF MEDICATIONS On April 24, 2023, at 11:55 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, including a review of the medication refrigerator in the locked medication room. LALD/CNS-A stated the current temperature of the medication refrigerator was 36.8 degrees Fahrenheit (F). LALD/CNS-A stated the temperature of the medication refrigerator was checked daily on the night shift and recorded on a paper log. The Cooler Temperatures log dated February 19, 2023, through April 23, 2023, where reviewed with LALD/CNS-A. The temperature of the refrigerator had been documented daily 60 times (with temperature readings not completed on March 22, 28, 29, and 30, 2023). Of the 60 recorded daily temperature readings; 52 of the	01880		

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01880	Continued From page 24 recorded temperature readings were below 36 degrees F (ranging from 32-41 degrees F). LALD/CNS-A stated the recorded medication refrigerator temperature was consistently below 36 degrees F. LALD/CNS-A was unsure of the acceptable temperature range for the medication refrigerator. The medication refrigerator contained two unopened bottles of latanoprost 0.005% ophthalmic solution (a glaucoma eye drop solution) for R5. On April 24, 2023, at 11:58 a.m., LALD/CNS-A stated the nurse office and medication room doors should be closed and locked when left unattended. The manufacturer's instructions for latanoprost eye drops dated, September 2020, indicated the unopened bottles should be stored in the refrigerator between 36 to 46 degrees F. The licensee's Storage of Medications policy dated September 2017, noted medications kept in central or secured storage must be kept in locked compartments under proper temperature controls and only authorized nursing personnel will have access to the keys. Refrigerators that are designated for medications will have staff document daily temperatures and will be adjusted for that specific temperature. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890	Continued From page 25	01890		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications for two of five residents (R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of 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: On April 24, 2023, at 11:29 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, including a review of the locked medication carts and medication room. LALD/CNS-A observed and confirmed the following: - R6's opened bottle of aspirin 325 milligram (mg) tablets expired August 2022 - R7's opened bottle of AZO Cranberry caplets (medication that hinders bacteria in the urinary tract) expired March 2023	01890		

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01890	Continued From page 26 On April 24, 2023, at 11:52 a.m., LALD/CNS-A stated either herself or registered nurse (RN)-B usually checked the medication carts and cupboards for outdated medications about once a month. LALD/CNS-A stated these medications must have been missed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33310	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF WADENA	110 HEMLOCK AVENUE NW WADENA, MN 56482

(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
02040	Continued From page 27 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). Findings include: A record review and interview were conducted April 26, 2023, at approximately 11:50 a.m. with Licensed Assisted Living Director/Clinical Nurse Specialist (LALD/CNS)-A on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD/CNS-A stated the facility had conducted this assessment but was not able to provide documentation or locate the assessment at the time of survey. LALD/CNS-A verified that the licensee was not able to provide a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33310	A. BUILDING: _____ B. WING _____	04/26/2023

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02110	Continued From page 28 must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. In addition, the licensee failed to	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33310	A. BUILDING: _____ B. WING _____	04/26/2023

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02110	Continued From page 29 ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility currently held an Assisted Living with Dementia Care license. The undated Special Care Unit Disclosure in Housing-With-Services Establishments document did not address the following required policies and procedures: - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications - description of family support programs and efforts to keep the family engaged - limiting the use of public address and intercom systems for emergencies and evacuation drills only	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02110	Continued From page 30 - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions On April 25, 2023, at 2:21 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the only dementia care policy that was provided to the resident and/or their representative was the Special Care Unit Disclosure in Housing-With-Services Establishment document. LALD/CNS-A stated some of the required policies had not been developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	02110		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *04/24/23*
Time: 10:30:47
Report: 7935231067

Food and Beverage Establishment Inspection Report

Location:
The Meadows Of Wadena
110 Hemlock Avenue Nw
Wadena, MN56482
Wadena County, 80

Establishment Info:
ID #: 0038302
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186323610
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

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NEED THERMOMETER THAT CAN RECORD MAX DISH MACHINE TEMP.

Comply By: 05/31/23

Surface and Equipment Sanitizers

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

Hot Water: = at 163 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Prep
Violation Issued: No

Process/Item: Cold Holding
Temperature: 33 Degrees Fahrenheit - Location: Walk In
Violation Issued: No

Type: Full
Date: *04/24/23*
Time: 10:30:47
Report: 7935231067
The Meadows Of Wadena

Food and Beverage Establishment Inspection Report

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

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

I acknowledge receipt of the MN Department of Health inspection report number 7935231067 of 04/24/23.

Certified Food Protection Manager: Jennifer Wirth

Certification Number: 49185 Expires: 04/05/25

Signed:_____ Signed: 7935

Establishment Representative

7935

651-201-4500
health.foodlodging@state.mn.us