Electronically Delivered

March 24, 2022

Administrator
Bridgewater At Janesville, LLC
543 Oakwood Drive
Janesville, MN 56048

RE: Project Number(s) SL32938015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 4, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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 enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should addressed to:

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32938	A. BUILDING: _____ B. WING _____	03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT JANESVILLE LLC	543 OAKWOOD DRIVE JANESVILLE, MN 56048

(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 Initial comments *****ATTENTION****** ASSISTED LIVING 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: SL32938015 On March 2 through March 4, 2022, 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 twenty (20) residents receiving services under the provider's 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 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 had the potential to affect all twenty (20) residents 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) 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 Reports,	0 480		

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0 480	Continued From page 2 dated March 3, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. The licensee failed to ensure appropriate personal protective equipment was worn while working in the facility for 1 of 6 staff, hospice caregiver (HC)-F, observed for universal COVID-19 precautions. The licensee further failed to ensure staff performed adequate hand hygiene for 1 of 2 staff, unlicensed personnel (ULP)-E, observed to deliver cares to residents. This had the potential to affect all twenty (20) residents, staff and visitors.	0 510		

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0 510	Continued From page 3 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: Facemask On March 2, 2022, at 11:25 a.m., during a facility tour with licensed assisted living director (LALD)-D, registered nurse (RN)-A and house manager (HM)-C, a caregiver was observed sitting at table in the first-floor dining area without a facemask on. The caregiver was later identified as a contracted hospice nurse, HC-F. No intervention by facility administration was observed. HC-F donned a facemask upon seeing administrative staff and the surveyor. -at 11:48 a.m., HC-F was again observed sitting at a table in the facility's first-floor dining area without a facemask on. HC-F stated she provided hospice cares for residents in the facility, and was currently training another hospice caregiver. A staff or visitor screening form completed March 2, 2022, at 9:15 a.m., indicated HC-F denied any symptoms for COVID-19, and attested to "wearing a secure mask". Signage was observed at the entrance to the facility which indicated all staff and visitors must wear a facemask while in the facility.	0 510		

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0 510	Continued From page 4 During an interview on March 2, 2022, at 12:18 p.m., RN-A verified hospice nurses, like all staff and visitors, were required to wear facemasks while in the facility. RN-A stated all staff were required to wear a facemask at all times and wear eye protection when within 6 feet of a resident for greater than 15 minutes or when providing direct cares. During an interview on March 4, 2022, at 10:49 a.m., RN-A acknowledged she observed HC-F without a facemask in place during the initial facility tour. RN-A indicated she contacted the hospice provider agency regarding the observation. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well fitting facemask and eye protection. In addition, it instructed HCW with no face-to-face contact with residents to wear a medical-grade well fitting facemask. Gloves/hand hygiene On March 3, 2022, at 8:56 a.m., ULP-E was observed to perform assistance with activities of daily living (ADLs) for R3. ULP-E was observed wearing a facemask, eye protection and gloves, and assisted R3 to ambulate to the bathroom and sit on the toilet. After assisting R3 to remove her clothing and soiled brief, ULP-E applied lotion, deodorant, and placed a clean brief and pants onto R3's lower legs, as well as socks and slippers, and assisted R3 to put on a bra. ULP-E removed her gloves. ULP-E assisted R3 to put	0 510		

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0 510	Continued From page 5	0 510		

on a shirt, brushed R3's hair, and asked R3 to stand. ULP-E was not observed to perform hand hygiene. ULP-E donned gloves, cleansed R3's perineal area with a cleansing wipe and pulled up R3's clean brief and pants before doffing gloves. R3 independently ambulated out of the room. ULP-E tied the bathroom garbage bag. ULP-E was not observed to perform hand hygiene. ULP-E donned one glove to her left hand, retrieved R3's upper denture plate with the gloved hand, and then straightened R3's bed with the ungloved hand. ULP-E donned a glove to the right hand and cleaned R3's denture plate with toothbrush and paste, dried with paper towel, and applied denture adhesive. ULP-E picked up and carried the garbage bag with upper denture plate together in her left hand. The denture plate was observed to be touching the garbage bag. ULP-E exited R3's room, set the garbage down on the floor, and gave the denture plate to R3 who independently inserted the denture plate. ULP-E then deposited the garbage bag in the utility room, doffed gloves, and performed appropriate hand hygiene.

During an interview on March 3, 2022, at 9:16 a.m., ULP-E stated she had orientation that included infection control education provided by house manager (HM)-C.

During an interview on March 3, 2022, at 9:20 a.m., RN-A acknowledged caregivers would be expected to perform hand hygiene when changing gloves after perineal care, and prior to assisting a resident with denture care, as well as after doffing gloves and upon exiting a residents room.

The CDC document titled, Interim Infection and Control Recommendations for Healthcare

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0 510	Continued From page 6 Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated September 10, 2021, indicated healthcare personnel (HCP) should perform HH before and after all patient contact, contact with potentially infectious material, and before donning and doffing personal protective equipment (PPE), including gloves. The CDC recommended alcohol-based hand sanitizer (ABHS) with 60% to 95% alcohol, or washing hands with soap and water for at least 20 seconds. The licensee's COVID-19: Infection Prevention & Control policy, dated March 13, 2021, indicated, "[licensee] will continue to follow basic core principles for preventing COVID-19 infection, including: a. Screening all who enter [licensee] for signs and symptoms of COVID-19, and deny entry to those with signs or symptoms or those who have had close contact with someone who has COVID-19 in the past 14 days regardless of the visitor's vaccination status. b. Hand Hygiene. An alcohol-based hand rub is best, unless hands are visibly soiled, and then soap and water is recommended. c. Wearing a well-fitting face mask that fully covers the mouth and nose. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's	0 730		

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0 730	Continued From page 7 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; (14) a discharge summary, including service termination notice and related documentation,	0 730		

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0 730	Continued From page 8 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 documentation of all provided services for two of two residents (R2, R3) with records reviewed. 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: R2, R3's medical records lacked documentation of services received. R2's service plan, dated January 11, 2022, indicated R2 received services for assistance with bathing-2x weekly (every Tuesday and Friday), dining-3x per day, housekeeping-weekly (every Tuesday), laundry-weekly (every Tuesday), pet feeding and litter box cleaning-daily, cueing/reminders for dressing-2x per day, and grooming-1x per day. R2's service record for February 2022 included, but was not limited to, the following services: bathing, dining, dressing, grooming, housekeeping, personal laundry, pet care	0 730		

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0 730	Continued From page 9 (feeding), and pet care (litter box) . R2's service record lacked the following documentation for February 2022: -5 out of 8 services for bathing; -54 out of 84 services for dining; -39 out of 56 services for dressing; -14 out of 28 services for grooming; -3 out of 4 services for housekeeping; -3 out of 4 services for personal laundry; -14 out of 28 services for pet feeding; and -14 out of 28 services for pet litter box cleaning. R3's service plan, dated January 29, 2021, indicated R3 received services for assistance with bathing-2x weekly (every Tuesday and Saturday), meals-2x daily, laundry-weekly (Saturday), dressing-2x daily, wellness checks every 2 hours (12x daily), and cueing/reminders for toileting-3x daily and grooming-2x daily. R3's service record for February 2022 included, but was not limited to, the following services: bathing, meals, housekeeping, personal laundry, dressing, toileting, and grooming. R3's service record lacked the following documentation for February 2022: -4 of 8 services for bathing; -31 of 56 services for meals; -2 of 4 services for personal laundry; -42 of 56 services for dressing; -234 of 336 services for wellness checks; -50 of 84 services for toileting; and -42 of 56 services for grooming. On March 4, 2022, at 10:49 a.m., registered nurse (RN-A) acknowledged service charting was missing several areas of documentation. RN-A stated "We are well aware of that issue." A policy regarding caregiver service	0 730		

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0 730	Continued From page 10 documentation was requested but not provided. 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	0 810		

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	32938	A. BUILDING: _____ B. WING _____	03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT JANESVILLE LLC	543 OAKWOOD DRIVE JANESVILLE, MN 56048

(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
0 810	Continued From page 11 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee training on fire safety and evacuation. 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 March 3, 2022, between approximately 10:00 a.m. and 10:30 a.m., with Licensed Assisted Living Director (LALD)-D and House Manager (HM)-C on the fire safety and evacuation plan and fire safety and evacuation training for the facility. Record review indicated that the fire safety and evacuation plan did not have fire protection procedures necessary for residents. During interview, (LALD)-D stated that the fire safety and evacuation plans did not include provisions for this requirement.	0 810		

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0 810	Continued From page 12 Record review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During interview, (LALD)-D stated that the fire safety and evacuation plans did not include provisions for this requirement. Record review indicated that employees did not receive training twice per year after initial hire on the facility fire safety and evacuation plan. During interview, (LALD)-D stated that the licensee provides training on fire safety annually per company policy. Record review indicated that that the licensee conducted fire drills in September of 2021 and January of 2022 but did not have further documentation indicating that evacuation drills had been conducted every other month as required. During interview, (LALD)-D stated that the licensee had not conducted any additional drills besides what had been documented and provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	01620		

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01620	Continued From page 13 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 a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initial assessment, and not to exceed 90 calendar days from the previous assessment for two of two residents (R2, R3) with records reviewed. 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). R2	01620		

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01620	Continued From page 14 R2's record lacked monitoring and reassessment within 14 days from the initial assessment. R2 was admitted December 28, 2021, and had diagnoses including type-2 diabetes, depression, anxiety, and hypertension (high blood pressure). R2's service plan, dated January 11, 2022, indicated R2 received services to include assistance with medication administration, activities of daily living (ADLs), bathing, meals, laundry, and housekeeping. R2's record included an initial assessment completed December 28, 2021, and a subsequent assessment completed February 9, 2022. R2's record lacked documentation an RN completed a 14-day assessment. R3 R3's record lacked monitoring and reassessment not to exceed 90 days from the previous assessment. R3 was admitted December 14, 2020, and had diagnoses including dementia, hypertension (high blood pressure) and anxiety. R3's service plan, dated January 29, 2021, indicated R3 received services to include assistance with medication administration, ADLs, bathing, toileting, meals, laundry, and housekeeping. R3's record included an assessment completed August 11, 2021, and a subsequent assessment completed November 12, 2021, 93 days after the previous assessment. As of the survey date, March 2, 2022, 110 days after the previous assessment dated November 12, 2021, no further	01620		

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01620	Continued From page 15 assessment had been completed for R3. During an interview on March 3, 2022, at 3:10 p.m., RN-A verified a 14-day assessment had not been completed for R2. RN-A further verified more than 90 days had passed since R3's latest assessment on November 12, 2021. The licensee's Initial and Ongoing Nursing Assessment of Residents policy, reviewed July 20, 2021, indicated, "A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01820 SS=D	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 written or electronically recorded prescriptions were	01820		

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01820	Continued From page 16 obtained for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted December 28, 2021, and had diagnoses including type-2 diabetes, depression, anxiety, and hypertension (high blood pressure). R2's service plan, dated January 11, 2022, indicated R2 received services to include assistance with medication administration. On March 3, 2022, at 8:10 a.m., unlicensed personnel (ULP)-B was observed to administer medications to R2. R2's medication administration record (MAR) for February 2022, indicated the following medications were administered to R2 daily during the month of February: aspirin, carvedilol (for high blood pressure), daily-vite tablet (multivitamin), duloxetine (for depression and anxiety), gabapentin (for pain), glimepiride (for diabetes), levothyroxine (thyroid medication), naltrexone (for alcohol abuse prevention), acetaminophen (pain reliever), miralax powder (for constipation), quetiapine (for anxiety), Trazodone (for anxiety), vitamin D3 (for vitamin D3 deficiency). R2's MAR further indicated the following medications to be	01820		

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01820	Continued From page 17 used on an as-needed basis: voltaren gel (for pain), hydroxyzine pamoate (for panic attacks), milk of magnesia (for constipation), acetaminophen (pain reliever), and glucose tablets (for diabetes). R1's record included a signed prescriber order for gabapentin 300 mg, three times daily, dated February 4, 2022. All remaining medications listed above for R2 were included on an order summary report dated December 28, 2021, but lacked a prescriber's signature. During an interview on March 4, 2022, at 10:49 a.m., registered nurse (RN)-A acknowledged prescriber orders for R2 were lacking a prescriber's signature. The licensee's Implementation of Medication Prescriptions and Treatment and Therapy Orders policy, revised February 1, 2018, indicated, "The Nurse or Licensed Health Professional will take necessary steps to obtain the prescriber's signature on any verbal orders or prescriptions as soon as possible and will document efforts to obtain the necessary signature." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	01940		

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01940	Continued From page 18 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R2) with records reviewed. 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	01940		

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01940	Continued From page 19 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted December 28, 2021, and had diagnoses including type-2 diabetes, depression, anxiety, and hypertension (high blood pressure). R2's service plan, dated January 11, 2022, indicated R2 received services to include assistance with medication administration, meals, bathing, housekeeping and laundry. The service plan lacked information regarding blood glucose monitoring for R2. R2's medication administration record (MAR), dated February 2022, indicated R2 had blood sugar levels checked twice daily on Monday, Wednesday and Friday, before breakfast and supper. On March 3, 2022, at 8:10 a.m. unlicensed personnel (ULP)-B was observed to check R2's blood glucose level. Although some information was present on the MAR, including the treatment to be provided and directions for when to notify the RN, R2's record lacked a treatment management plan for blood glucose monitoring to include the following: -Documentation of specific resident instructions relating to the treatment or therapy service administration; -Identification of treatments or therapy tasks that would be delegated to ULP in accordance with current standards of delegation practice; -Any resident-specific requirements relating to	01940		

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01940	Continued From page 20 documentation of treatment and therapy received, verification all treatment and therapy was administered as prescribed and monitoring of treatment or therapy in an effort to prevent possible complications or adverse reactions. During an interview on March 3, 2022, at 3:10 p.m., registered nurse (RN)-A verified R2's service plan did not include information regarding blood glucose monitoring for R2. RN-A further stated the treatment and therapy management information was included in MAR, and that there was no separate treatment and therapy management plan. The licensee's Delegation of Nursing Tasks policy, revised July 20, 2021, indicated when a treatment or therapy is delegated or assigned to unlicensed personnel, the RN or authorized Licensed Health Professional must develop and maintain a current individualized treatment or therapy management record for each resident. No further information is available. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must	01960		

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01960	Continued From page 21 document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not administered, and any follow up procedures that were provided to meet the resident's needs, for one of one resident (R2) receiving blood glucose monitoring services with records reviewed. 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: The licensee failed to ensure the registered nurse (RN) was notified of R2's blood glucose level being out of range, as ordered. R2 was admitted December 28, 2021, and had diagnoses including type-2 diabetes, depression, anxiety, and hypertension (high blood pressure). R2's service plan, dated January 11, 2022, indicated R2 received services to include assistance with medication administration, meals, bathing, housekeeping and laundry. The service plan lacked information regarding blood glucose monitoring for R2.	01960		

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01960	Continued From page 22 R2's medication administration record (MAR), dated February 2022, indicated R2 had blood sugar levels checked twice daily on Monday, Wednesday and Friday, before breakfast and supper, and, "Notify on call nurse if blood sugars are higher than 350 and lower than 80". On March 3, 2022, at 8:10 a.m. unlicensed personnel (ULP)-B was observed to check R2's blood glucose level. ULP-B verbalized and was observed to document R2's blood glucose level reading of 67. ULP-B failed to notify the RN of the blood glucose level reading below 80. ULP-B's personnel record included training in documentation requirements for all services provided, dated August 1, 2021. The training outline included notifying the nurse of a change or emergent condition. During an interview on March 3, 2022, at 9:20 a.m., RN-A stated she had not been notified of a blood glucose reading below 80 for R2. RN-A stated it would be her expectation to be notified immediately, "within about 5 minutes", of a blood glucose reading outside the indicated parameters. A policy on updating the RN regarding treatment or therapies being administered was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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02040	Continued From page 23 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 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 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 March 3, 2022, between approximately 10:00 a.m. and 10:30 a.m., with Licensed Assisted Living Director (LALD)-D and House Manager (HM)-C on the hazard vulnerability assessment	02040		

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02040	Continued From page 24 for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-D stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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

Type: Full
Date: *03/03/22*
Time: 08:29:48
Report: 8044221048

Food and Beverage Establishment Inspection Report

Location:
Bridgewater At Janesville Llc - Upper Kitchen
543 Oakwood Drive
Janesville, MN56048
Waseca County, 81

Establishment Info:
ID #: 0037764
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073880645
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.

3-800 Highly Susceptible Populations

3-801.11B ** Priority 1 **

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

Unpasteurized eggs used for eggs cooked with runny yolks.

Comply By: 03/03/22

3-500A Microbial Control: cooling

3-501.15B ** Priority 2 **

MN Rule 4626.0390B Loosely cover containers of cooling food and arrange in cold holding equipment in a manner to maximize heat transfer through the container walls.

Meatloaf and omelets cooling in covered containers.

Comply By: 03/03/22

Surface and Equipment Sanitizers

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

Food and Beverage Establishment Inspection Report

Bridgewater At Janesville Llc - Upper Kitchen

Hot Water: = at 172.6 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooling
Temperature: 76.7 Degrees Fahrenheit - Location: Omlets @ 8:42am
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37.0 Degrees Fahrenheit - Location: Upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41.0 Degrees Fahrenheit - Location: Soup in upright
Violation Issued: No

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

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

Sanitarian Comments:

Inspection conducted in conjunction with MDH Health Regulation Division.
Lead RN evaluator: Renee Anderson

Report reviewed with Sarah and Taya. Potential hazards in day-to-day operation were discussed, including employee illness, excluding/restricting employees experiencing illness symptoms, recording employee illness symptoms, proper hand washing methods, restriction of bare hand contact with ready-to-eat foods, monitoring food temperatures and training all employees in all aspects of food safety. Person in charge and food employees demonstrated adequate knowledge of operating a safe food establishment.

Type: Full
Date: *03/03/22*
Time: 08:29:48
Report: 8044221048
Bridgewater At Janesville Llc - Upper Kitchen

Food and Beverage Establishment Inspection Report

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 8044221048 of 03/03/22.

Certified Food Protection Manager: Taya M. Rux

Certification Number: FM107189 Expires: 07/20/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Sarah

Signed: _____
Michael DeMars, RS
Public Health Sanitarian III
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