DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 23, 2023

Licensee
Sugar Loaf Senior Living
765 Menard Road
Winona, MN 55987

RE: Project Number(s) SL28896015

Dear Licensee:

On February 21, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 2, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

Electronically Delivered

January 6, 2023

Licensee
Sugar Loaf Senior Living
765 Menard Road
Winona, MN 55987

RE: Project Number(s) SL28896015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 2, 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.

LICENSING ORDERS
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
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring = $3,000
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000

The total amount you are assessed is $6,500. 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:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the 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,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 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
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(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 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: SL28896015-0 On November 28, 2022, through December 2, 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 81 residents, all of whom received services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on November 30, 2022, issued for tag identification 2310. On December 1, 2022, the immediacy of correction order 2310 was removed; however, non-compliance remained at a level 3, isolated scope violation.	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1	0 250		

provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:
(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;
(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;
(3) performs any act detrimental to the health, safety, and welfare of a resident;
(4) obtains the license by fraud or misrepresentation;
(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;
(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;
(7) interferes with or impedes a representative of the department in contacting the facility's residents;
(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4;
(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;
(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;
(11) refuses to initiate a background study under section 144.057 or 245A.04;
(12) fails to timely pay any fines assessed by the

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. 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: During the entrance conference on November 28, 2022, at 10:00 a.m. licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar	0 250		

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0 250	Continued From page 3 with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets	0 250		

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0 250	Continued From page 4 requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of	0 250		

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0 250	Continued From page 5 Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by LALD-A on May 12, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of July 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (2) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (3) orientation to and implementation of the assisted living bill of rights; (4) infection control practices; (5) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control	0 250		

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0 250	Continued From page 6 and Prevention standards; (6) medication and treatment management; and (7) delegation of tasks by registered nurses or licensed health professionals. As a result of this survey, the following orders were issued 0510, 0650, 0660, 1620, 1700, 1710, 1730, 1760, 1820, 1880, 1890, 1910, 1940, 1960, 2240, and 2310 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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	0 480		

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0 480	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all 81 current 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated November 28, 2022. 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	0 510		

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0 510	Continued From page 8 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control with proper hand hygiene for five of five unlicensed personnel (ULP-D, ULP-H, ULP-E, ULP-F, ULP-G). 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During continuous observation on November 29, 2022, at 6:50 a.m. unlicensed personnel (ULP)-D administered oral and inhaled medications to R6. She put on gloves, applied lotion to R6's lower legs and applied tubi-grips (compression stocking), she then removed her gloves, and made R6's bed. Without washing her hands or using hand sanitizer, ULP-D went to R8's room and escorted her to breakfast. Without washing her hands or using hand sanitizer, ULP-D went to R9's room, set up her wheelchair for her to transfer into, made her bed, opened her blinds,	0 510		

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0 510	Continued From page 9	0 510		

and switched over her laundry. ULP-D failed to wash hands or use hand sanitizer throughout the observation. ULP-D verified there were hand sanitizer stations in each hallway for use in between residents.

On November 29, 2022, at 7:05 a.m. ULP-H was observed to administer oral medications to R12 while in his room. Following medication administration, ULP-H documented on the medication administration record (MAR) found on the electronic tablet that she carried with her from room to room. ULP-H left R12's room and without washing their hands, entered another resident's room to start morning cares.

During continuous observation on November 29, 2022, at 8:02 a.m. ULP-E administered oral medications to R7. ULP-E then put on gloves, checked R7's blood glucose, removed her gloves and disposed of the lancet and blood glucose strip into the sharps container. Without washing her hands or using hand sanitizer, ULP-E and ULP-F went to R15's room to complete urinary catheter cares. R15 had an indwelling urinary catheter attached to a drainage bag, the drainage bag was lying on the floor. ULP-E picked up the bag, manipulated the tubing to assist the drainage from the tubing into the bag, and hooked the bag onto the bed frame. ULP-E applied gloves and wet a washcloth, which she brought to R15 to wash her eyes with. ULP-F applied gloves and changed the catheter drainage bag to a leg bag. She brought the drainage bag to the bathroom, drained and cleaned it. She removed her gloves and attached the leg bag to R15's leg. ULP-E and ULP-F exited the room and were going to other apartments to complete cares and medication passes, in which time the surveyor intervened. ULP-F verified

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0 510	Continued From page 10	0 510		

there were hand wash stations on each floor in the bathrooms. Staff were expected to remove their gloves and use hand sanitizer, and after exiting the resident room they were to wash their hands.

On November 29, 2022, at 8:15 a.m. ULP-G entered R13's room carrying an electronic tablet, greeted R13, entered the locked medication cabinet in his room, gathered equipment needed to complete a blood glucose check and prepared an insulin pen with the proper dosage to be given. ULP-G put on gloves, completed R13's blood glucose check, and assisted R13 with pulling up his shirt to allow the insulin injection to the abdomen. ULP-G injected the proper amount of insulin, pulled R13's shirt back into place, moved to the medication cabinet to dispose of the blood glucose strip, removed her gloves and returned the insulin pen to the medication cabinet. ULP-G continued with medication set up and administration of R13's oral medications. ULP-G documented on the MAR, and left R13's room to assist another resident transfer via wheelchair from the living room area to the dining hall.
No hand washing was observed prior to blood glucose monitoring equipment preparation, between performing blood glucose check and administration of oral medications, following the use of the electronic tablet, before leaving R13's room, nor before contact with another resident.

On November 29, 2022, at 10:30 a.m. the surveyor observed ULP-G and ULP-F enter an unidentified resident's room, assisted with an EZ stand (mechanical lift) transfer from the bed to a chair in the room. Both ULP-G and ULP-F left the resident's room to another area of the memory care unit. No hand hygiene was observed by either ULP prior to, or following the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(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
0 510	Continued From page 11 transfer. On November 29, 2022, at 11:30 a.m. registered nurse (RN)-B stated her expectation was for hand washing to be performed each and every time the ULP entered and exited a resident's room and following glove use. RN-B stated she would provide additional training and reminders for staff. The licensee's Hand Hygiene policy dated July 2021, identified "Proper hand washing techniques should be used to protect the spread of infection. Cleaning your hands reduces the spread of potentially deadly germs to the resident and reduces the risk of healthcare provider colonization or infection caused by germs acquired from the resident. Hand hygiene may occur multiple times during a single care episode. Following is a guide of clinical indications for hand hygiene." "Hand washing shall be performed by all employees, as necessary, between tasks and procedures, and after bathroom use to prevent cross-contamination." "Hand Hygiene Using Alcohol-Based Hand Sanitizers (ABHS) -ABHS should not be used as a replacement for proper hand washing when hands are visibly soiled. When hands are not visibly soiled, alcohol-based hand sanitizer is an efficient and effective method for hand hygiene. Using an alcohol-based hand sanitizer that contains at least 60% alcohol is the preferred method for hand hygiene to quickly reduce the number of germs on hands." "Hand Hygiene and Gloves - When conducting a procedure requiring the use of gloves, proper hand hygiene shall be completed before donning gloves and after removing gloves. Gloves must be changed between different cares along with proper hand hygiene/disinfecting to prevent	0 510		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 510	Continued From page 12 cross-contamination; this includes changing gloves during cares for the same resident (example: going from toileting to oral care, new gloves and hand hygiene must be performed). Refer to Guideline: PPE Selection and Use." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors.	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 640	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on November 28, 2022, at approximately 12:30 p.m. with licensed assisted living director (LALD)-A, the common areas shared by residents, staff, and visitors, lacked posted information and phone numbers for reporting to MAARC and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. LALD-A confirmed the required posting was not present in the common areas, and she was unaware she was missing the posting. The licensee's Vulnerable Adult/Maltreatment - Communication, Prevention, and Reporting policy dated August 2019, identified "Consistent with the Minnesota Vulnerable Adults Act and Home Care Regulations [the licensee] prohibits the maltreatment of Nursing Home or home care clients. To support this, [the licensee] educates clients, family members, and staff about how to report suspected maltreatment, and provides individualized staff assessments, staff tools, and resources to minimize the risk of maltreatment of a client."In compliance with the Minnesota Vulnerable Adult Act "VAA", Minn. Stat. 626.557, [the licensee] has instituted the policy to protect adults who,	0 640		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 640	Continued From page 14 because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment; to assist in providing safe environments for vulnerable adults; and to provide safe institutional or residential services, community-based services, or living environments for vulnerable adults who have been maltreated. In addition, it is the policy of Sugar Loaf Senior Living to require the reporting of suspected maltreatment of vulnerable adults, to provide for the voluntary reporting of maltreatment of vulnerable adults, to require the investigation of the report, and to provide protective and counseling services in appropriate cases." The policy did not include information regarding the mandatory posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;	0 650		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 650	Continued From page 15 (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for three of three employees (unlicensed personnel (ULP)-F and ULP-G, and registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-G ULP-G's personnel file identified she was hired on August 21, 2019.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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0 650	Continued From page 16	0 650		

ULP-G's employee record identified a performance evaluation completed August 28, 2020.

ULP-G's employee record lacked evidence a performance evaluation had been completed in the last year.

ULP-F
ULP-F's personnel record lacked an annual performance evaluation.

ULP-F had a hire date of July 30, 2020, and provided direct care services under the licensee's assisted living with dementia care license.

ULP-F's personnel record included an annual performance review dated July 30, 2021, but lacked evidence of an annual performance review for the past year.

RN-B
RN-B's personnel file identified she was hired on June 22, 2021.

RN-B's employee record identified she had a performance evaluation on September 22, 2021. There was no evidence a performance evaluation had been completed in the last year.

On December 2, 2022, at 11:05 a.m. licensed assistant living director (LALD)-A stated the employee evaluations should have been completed around the anniversary date of their hire so that they were completed annually.

The licensee's HR Policy 200: Personnel Records & Retention policy dated October 2021, identified "All employees' personnel records, including application forms, individual attendance records,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(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
0 650	Continued From page 17 medical history, performance evaluations, disciplinary warnings, separation action forms, exit interview records, withholding information, garnishment information, drug test. and background investigation/security checks results should be kept indefinitely in a safe, secure, dry environment." The policy did not address the frequency of performance evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 18	0 660		

the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for three of four employees (unlicensed personnel (ULP)-E, ULP-F, and ULP-G).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:

The licensee's TB facility risk assessment dated May 23, 2022, indicated they were a low risk.

ULP-E
ULP-E's personnel file identified she was hired on October 10, 2022. ULP-E had a TB quantiferon (TB blood test) dated October 6, 2022, that was negative. The personnel file had no evidence a TB symptom screening was completed upon hire, or within 90 days prior to the hire date.

ULP-F
ULP-F had a hire date of July 30, 2020, and provided direct care services under the licensee's assisted living with dementia care license.

ULP-F's personnel file included a document "Reference Lab Results" from a hospital provider dated August 14, 2020, and indicated "QuantiFERON-Tb Gold Plus Result: Negative." There was no indicated evidence of a screening

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 19 and symptom tool being completed at that time. ULP-G ULP-G's personnel file identified she was hired on August 21, 2019. ULP-G had a TB quantiferon (TB blood test) dated August 7, 2019, that was negative. The personnel file had no evidence a TB symptom screening was completed upon hire, or within 90 days prior to the hire date. On December 2, 2022, at 11:05 a.m. licensee assisted living director (LALD)-A and registered nurse (RN)-K stated the symptom screen had been completed at the clinic when the staff had the TB quantiferon blood test completed. At some point the clinic stopped completing the symptom screening and the licensee was unaware. The screenings should have been completed at the time of hire. The licensee's TB Infection Control Plan policy dated September 2021, identified "Tuberculosis screenings are required for all employees who share the same air space as the resident/tenant, both paid and unpaid, at the time of hire or more often as indicated." "Baseline screening is required for all health care workers. Baseline screening consists of three components: · Assessing for current symptoms of active TB disease · Assessment of TB history · Testing for the presence of m-tuberculosis by administering the two-step TST or single BAMT." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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0 660	Continued From page 20 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 730	Continued From page 21 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, 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 observation, interview, and record review, the licensee failed to ensure documentation of wound condition and measurements and failed to document collaboration of care with the home health agency and hospice agency for one of one resident (R14) receiving wound care services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 22	0 730		

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:

R14's Service plan (unsigned) dated August 17, 2022, indicated services included medication management, toileting/incontinence assistance, bathing assistance, wound management, medical monitoring, exercise program, meal assistance and safety checks.

R14's diagnoses included vascular dementia with behavioral disturbance (a type of dementia caused by conditions that damage blood vessels and block blood flow to the brain causing cognitive changes with thinking and behavior), lymphoma and chronic kidney disease.

On November 29, 2022, at 7:40 a.m. the surveyor observed unlicensed personnel (ULP)-I administer oral medications, wash R14's face, provide oral care, repositioning in bed and ensured vascular boots/heel protectors were in place. ULP-I stated "The hospice nurse manages all of the wound care for the resident's left heel, we just make sure the heel boots are in place and his heels are off the bed."

LEFT HEEL WOUND DOCUMENTATION

R14's progress note dated August 8, 2022, indicated new evidence of a left heel wound. The progress notes included wound related entries as follows:
-August 8, 2022 at 5:40 a.m. as entered by [licensee's contracted] on call registered nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 23	0 730		

(RN) that read "Update to left foot- Nurses found blood in his bed near left heel. Quarter size spot to heel that looks dark purple around edges, that appears it could be a blood blister. Does not appear to have any depth to it like a pressure wound. He is responsive verbally to confused dementia at baseline. Speech mostly nonsensical. Did say 'ouch' while in chair, but once up, client not responding in any signs of pain to touch. HHAs do not have wound cleanser, but able to cover with sterile gauze and secured with tape. Back up in bed and leg elevated on pillow. Does have some red streaking to inner ankle partially up the side of leg. Does feel warm to touch. Warmer than right side. T-97.2 BP-108/78 P-73 02-93% [licensee's documentation system] does note he had some spots they were watching for signs of infection on left foot. HHA [home health aide] explains they usually have a nurse starting at 6 a.m. but may arrive shortly after. Client now comfortable in bed and starting to sleep again. Ok to check on client 10-15 min make sure not bleeding
through. And see if we can wait for nurse to arrive before next steps.
6:30 AM Writer calls back to HHAs [home health aides] to check status and follow up. HHAs report their nurse did not arrive so they had already updated their DON [director of nursing], DON is aware of [R14's] foot concern and status at this time. She updated HHAs that she will follow up and will be in. HHAs state client is still comfortable and resting in bed."
-August 8, 2022, at 10:24 a.m. by RN-B, "This writer looked at area on left heel. Some bleeding noted. Area is dark in color and resident having some pain associated with wound. Son Bill was called and was updated. This nurse stated that I could see if [provider] would be willing to do a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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0 730	Continued From page 24	0 730		

referral with [Home Care agency] but it could take a few days to have this started. [R14's] son is in agreement to have this started. A call was placed to [provider] to start process."
-August 9, 2022, at 8:59 p.m. indicated, "Resident was seen by [provider name] today. [homecare services] for wound care to the blister/pressure injury on the left heel. Please reach out if we need podiatry involvement. Try to lie down 2 times per day with heels offloaded Encourage patient to keep foot/heel elevated when in wheelchair."
-August 23, 2022, indicated, "New Order: Per [provider name], Will change wound care orders to utilize Dakins solution and cover with gauze-likely needs debridement. Due to pain with today wound care suggest tramadol 25 mg [milligrams] prior to wound care. 1)Start Tramadol 25 mg PO [orally] scheduled daily prior to wound care. (Discuss with [home care] wound nurse about timing). 2) Increase furosemide to 40 mg daily for 7 [seven] days then decrease back to 20 mg daily thereafter RE: edema."
-August 24, 2022, read "Discussed with resident's case manager from [home care agency name] a good time to schedule tramadol. Nurse stated that 0930 would be best. Tramadol scheduled for 0920 daily. [H New Order -Per [provider's name], 1) clean the wound base on the left heel with Dakins solution daily. Apply square of aquacel Ag, cover with ABD for padding protection, wrap with kling. (until wound care appointment. [home health agency name] plans to do visits M-F and [licensee] does dressing changes on Saturday and Sunday.
-August 27, 2022, read "Wound care done using sterile technique. Does complain of pain when lifting leg and changing the dressing. Foul odor noted. Appears to be getting worse.
-August 29, 2022, read "Resident was seen by [provider name] today. Pressure ulcer posterior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 25 left heel. 3.0 cm [centimeters] x 3.5 cm. No infection noted. Weight needs to be kept off the ulcer site when laying down. Place a pillow under the leg so heel hangs off. Use padded vascular boot when out of bed. Home health to continue dressing changes daily. See again in one month." -September 2, 2022, at 1:51 p.m. read "Per HCA [home care aide] resident had emesis early this morning. Nurse received call from [provider name] to assess resident and get set of vitals. [Home health agency name] reported foul smell and small amount of drainage coming from wound. Resident is pale looking. All of resident's extremities are cold half wall [sic] up. Resident's lung sounds are clear and bowel sounds hypoactive. Resident sounds full phlegm in throat and is unable to clear it. Vital Signs: BP-109/74 and 111/74, P-61, T-97.8, R-22. Resident has not had any more emesis since early this morning. Resident approx. 75% of breakfast and lunch. Message left for [provider's name]." -September 2, 2022, at 5:10 p.m. read "Per [provider's name] recommendation, resident was sent to [hospital name] ED [emergency department] for evaluation d/t [due to] low oxygen sats [saturation level] and upper and lower extremities cold to the touch. Resident left the building at 4:45 p.m. via non-emergent ambulance. -September 3, 2022, read "Writer was able to get an update on resident. He was admitted for elevated liver enzymes. He is receiving IV antibiotics. They are running tests to try and rule out possible gall bladder issues." -September 18, 2022, read "Tenant appears to be doing well this am shift. Writer fed him and he ate very well and took his medications as scheduled." -September 21, 2022, read "The Resident has been fighting a foot wound presently and there have been reports of decline as well. Staff has	0 730		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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0 730	Continued From page 26	0 730		

reported that the resident almost always needs assistance with eating, has been eating smaller amounts, and has been sleeping more than normal. The resident has days where he is more awake and verbal and he still joins in for activities and exercise with the group."
-September 27, 2022, read "Resident was seen by Forsyth today. Forsyth did briefly discuss with son Paul about hospice for resident; especially if resident has more trouble swallowing. D/C [discontinue] Senna 3 times per week. Start Senna/docusate 8.6-50 MG 1 tab 3 times a week. Obtain CMP next week lab day RE: transaminitis."
-September 28, 2022, read "Resident was admitted to Hospice today. RN has ordered resident a Broda chair and called Podiatry to cancel his appointment for tomorrow as she believes Hospice can manage the wound on his left heel."
-September 29, 2022, read "Wound care: dressing change every other day, Hospice will do Monday and Wednesday. AL[assisted living] RN to do dressing change on Friday and once on the weekend. Dressings are in the room call if more are needed. Left wound care; cleanse with wound cleanser, dry with 4x4. Dampen cut Kerlix squares with Dakins and apply to wound bed, protect peri wound area, cover with white mepilex wrap with Kling. Apply boot and keep elevated, keep pressure off the heel."
-October 2, 2022, read "Wound care completed approximately 1.5 hours post PRN (as needed) morphine. Resident winces with removal of old dressing after having been saturated with wound cleanser for easier removal. Wound has a strong foul odor, serosanguineous drainage is visible on layers of dressing to the white mepilex foam. Cleaned with wound cleanser and treatment completed with Dakins damp 4x4 held in place

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 730	Continued From page 27 with white mepilex foam and kerlix." -October 6, 2022, read "Hospice to take over dressing changes. Change will be three times a week. D/C previous dressing changes. Will start kerrafoam AG, cover with kerlix and boot 3 x per week." -October 15, 2022, read "Wound on the left heel no longer has an odor. Center is irregularly shaped with hard yellow/brown slough tissue surrounded by deeply red tissue, especially into the plantar surface of the heel. The superior edge is more dry in appearance, brownish pink with a distinct line of change in depth to the outer edge of the wound. Moderate amount of serosanguineous drainage on the Mepilex AG foam. Dampness through the layer of 4x4." -November 16, 2022, read "Received fax from Hospice. - Morphine 5 mg every 8 hours for pain. Apply vascular boots to both feet at all times, except during cares." -November 17, 2022, read "There have been no changes to the resident's foot condition." R14's record included one document named "Weekly wound note-Non Pressure", dated August 21, 2022. This note included the following information: - Site/location of: left heel; - Type of wound/lesion: Other open lesion of the foot-Rashes, ulcers, cuts laceration; - Measurements/Drainage/Tissue Appearance: size 3.0 cm (centimeters) X 3.5 cm, Depth-0.1 cm, Exudate (drainage) type: Serosanguineous, Exudate amount-small, Undermining: yes, Odor: yes, Epithlialization: no, Granulation: no, Slough: no, Necrosis: no, Surrounding skin color: Normal skin color, Surrounding Tissue/Wound Edges: Peripheral tissue edema; - Current Treatment: Cleanse wound, cover with	0 730		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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0 730	Continued From page 28 opticel and wrap with gauze daily, Response to treatment: unchanged, Sign/Symptoms of infection: Failure to improve, -Nutritional/Hydration Status: Ideal body weight: At IBW (ideal body weight), food intake: 50-75%, Skin Turgor: Fair, -Preventative measure/Progress: Pressure relieving interventions including elevate foot with pillow in bed so heel hangs off. Wear vascular boot when awake, and; -Pain: Is tenant experiencing pain related to wound:Yes, Explain pain regimen: Resident has scheduled Tylenol 650 mg TID [three times daily] and has scheduled Tramadol prior to dressing change. The licensee lacked documentation of R14's wound condition and measurements on a weekly basis, and when the licensee's nurses provided wound care on weekends, the licensee lacked documentation by the home health agency or evidence of nursing collaboration during the home health agency's care of R14's wound, and the licensee lacked documentation by the hospice agency or evidence of nursing collaboration with R14's wound care to include wound measurements and the condition of the wound. On November 30, 2022, at 9:40 a.m. the surveyor observed hospice registered nurse(RN)-J provide wound care to R14. RN-J completed measurements of R14's left heel to include a new area that measured 2.0 cm x1.0 cm. The previous wound area measured 2.5 cm. x 1.0 cm. RN-J cleansed the wound with Dakins solution, covered it with a mepi-foam Ag dressing and wrapped the dressing and foot with a kerlix wrap. She then placed vascular boot/heel protector and ensured pillows were placed to prevent pressure to the bottom of both heels. When asked about	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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0 730	Continued From page 29	0 730		

whether the licensee's nurses came to view the wound during hospice provided wound care, RN-J shook her head "no" and stated, "I don't have access to their [the licensee's electronic medical record] to document. I usually just visit with the nurse after my visit. I started faxing information, but I no longer do that. I tend to write on the marker board [pointed to a marker board on the wall in R14's room] when I want staff to know something."

On November 30, 2022, at 10:30 a.m. when asked how often she sees R14's left heel wound, RN-C stated, "I have not looked at his [R14's] heel since last week, no."

On December 1, 2022, at 12:15 p.m. when the surveyor asked about home health agency documentation, RN-B stated, "We no longer have it. When the home health agency discharges a patient, they take the record with them." At 3:00 p.m., RN-B provided one home health agency document that included three entries that only included information about R14's pain and a final entry regarding a successful discharge. No wound condition or measurements were documented. When the surveyor asked for hospice documentation, RN-B stated, "We don't have anything, the nurse just chats with the RN in the memory care unit."

On December 1, 2022 at 2:55 p.m. the surveyor reviewed with RN-B the one document provided as a wound assessment dated August 21, 2022, to which RN-B stated "There should have been weekly documentation about his [R14's] left heel wound by the licensee's nurses as it was an assigned task in the Service Plan Check Off. RN-B reviewed documentation on the Service Plan Check Off dated November 2022, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 30 indicated ULP-H's initials were entered on November 5, 10, and 17, 2022, with the note "completed by hospice nurse." RN-B stated, "It appears some of the dates lined up with the team lead [ULP] to do and ULP-H likely did not realize this task needed to be completed by the [licensee's] nurse and assumed it was sufficiently managed by the hospice nurse. RN-B stated " ULP-H should have notified an RN this task needed to be completed. We dropped the ball in monitoring this nursing task. I will update the comment section to indicate this task needs to be completed by [the licensee's] nurse." RN-B confirmed the licensee's nurses failed to complete weekly documentation of wound measurements and wound condition. On December 1, 2022, at 4:00 p.m. RN-B presented the surveyor with R14's hospice records, and stated, "I had to request these, they were sent today, and I will start a hospice binder immediately." The licensee's Client record policy dated July 2021, indicated the residents' record would include, all records of communications pertinent to the client's services, documentation of significant changes in the client's status and actions take in response to the needs of the client, and documentation that services have been provided as identified in the service plan. In addition to scheduled tasks, other pertinent information that should be documented in a client's chart include but are not limited to: new problems, health concerns, medication changes, appointments, falls, incidents and concerns. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one	0 730		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 31 (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the facility in good repair in regards to resident health and safety in accordance with maintenance and repair program. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: 1. On 11/30/2022 between 09:45 AM to 12:15 PM, survey staff observed during the tour of the facility that on the 2nd FL - Dining Room, an extension cord was connected to a 3-to-1 multi-tap adapter	0 800		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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0 800	Continued From page 32 2. On 11/30/2022 between 09:45 AM to 12:15 PM, survey staff observed during the tour of the facility that on the 2nd FL, the smoke barrier door adjacent to RM 211, exhibited a door-to-door separation greater than 1/8 inch which would readily allow the transfer and movement of smoke 3. On 11/30/2022 between 09:45 AM to 12:15 PM, survey staff observed during the tour of the facility that on the 2nd FL Kitchen, the K-extinguisher was missing its inspection tag 4. On 11/30/2022 between 09:45 AM to 12:15 PM, survey staff observed during the tour of the facility that on the 1st FL in RM 004, power strips were found to be daisy-chained together 5. On 11/30/2022 between 09:45 AM to 12:15 PM, survey staff observed during the tour of the facility that on the 1st FL in Garage 121, excessive combustible storage was exhibited MS-L verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 970 SS=A	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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0 970	Continued From page 33 include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for one of five residents (R13). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at 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: R13 was admitted to the assisted living with dementia care on August 1, 2021, and had an assisted living contract dated August 30, 2021. R13's assisted living contract included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. The facility's contract contained the following: "2. INDEMNIFICATION Resident will indemnify and hold harmless Provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(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
0 970	Continued From page 34 premises or any other part of Provider's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents." "4. LIABILITY Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third party providers. Provider may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises." On November 30, 2022, at 8:50 a.m. licensed assisted living director (LALD)-A stated the licensee had updated the contract with an amendment. In addition they had made more changes to the contract and have a new version that does not include the waivers of liability. R13 should have had a signed amendment to regarding the indemnification and waivers of liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
01060	Continued From page 35	01060		
01060 SS=F	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; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01060	Continued From page 36	01060		

refusal to provide housing or services constitutes a termination and triggers the termination process in this section.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide a written notice with required content, to the resident, legal representative, and designated representative, for an emergency relocation for two of two residents (R14, R20). In addition, the licensee failed to notify the Office of Ombudsman for Long-Term Care of the relocation within four days as required.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:

R14 and R20's records failed to identify the residents, and the residents' representative had been provided as soon as practible and the a written notice that contained, at a minimum:
-the reason for the relocation;
-the name and contact information for the location to which the resident has been relocated and any new service provider;
-contact information for the Office of Ombudsman for Long-Term Care;
-if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01060	Continued From page 37	01060		

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.
R20's record failed to notify Office of Ombudsman for Long-Term Care of the relocation within four days.

R14
R14's nurse's progress note dated September 2, 2022, indicated R14 was sent to the hospital and admitted for further evaluation of low oxygen saturations and cold extremities. R14 was hospitalized with elevated liver enzymes and IV (intravenous) antibiotic treatment for a left heel ulcer.

R14's hospital discharge record dated September 6, 2022, indicated R14 returned to the facility on September 6, 2022, with final discharge diagnoses including, presumed choledocholithiasis (a condition where gall bladder stones enter and block the common bile duct), acute on chronic kidney failure, vascular dementia with behavioral disturbance, constipation due to neurogenic bowel, and left heel wound.

R20
R20's progress notes identified on July 18, 2022, R20 was sent to the emergency room and was subsequently admitted to the hospital with pneumonia. On July 27, 2022, R20's case manager notified the facility R20 would require a higher level of care and would not be returning to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01060	Continued From page 38 R20's discharge summary dated August 15, 2022, identified R20 was discharged on July 18, 2022, due to the licensee being unable to meet her needs. On December 1, 2022, at 8:20 a.m. registered nurse (RN)-B stated she was unaware of the requirement, the required written notice had not been completed, and written notice was not provided to the resident, legal representative, or designated representative. RN-D also said the Office of Ombudsman for Long-Term Care was not given notice when the resident was relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=I	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 39	01620		

the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the licensee failed to complete a change of condition assessment for two of two residents (R14, R12) resulting in actual harm to R14. In addition, the licensee failed to complete comprehensive assessments on three of three residents (R13, R6, and R15) every 90 days.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R14
R14's record lacked an RN assessment with a change in condition following the development of a left heel wound, a hospitalization, the initiation of hospice services and lacked ongoing wound assessments by the licensee.

R14's Service plan (unsigned) dated August 16,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 40	01620		

2022, indicated services included medication management, toileting/incontinence assistance, bathing assistance, meal assistance, wound management, skin care and safety checks.

R14's diagnoses included vascular dementia with behavioral disturbance (a type of dementia caused by conditions that damage blood vessels and block blood flow to the brain causing cognitive changes with thinking and behavior), lymphoma and chronic kidney disease.

On November 29, 2022, at 7:40 a.m. the surveyor observed unlicensed personnel (ULP)-I administer oral medications, wash R14's face, provide oral care, repositioning in bed and ensured vascular boots/heel protectors were in place.

On November 30, 2022, at 9:15 a.m. LALD-A provided the surveyor with a list of RN assessments for R14 with the following dates: January 21, 2022, April 19, 2022, April 22, 2022, September 20, 2022, and October 21, 2022.

R14's progress notes indicated a new left heel wound, wound care management by a home health agency, a hospitalization, and the initiation of hospice services with the following entries:
-August 8, 2022 at 5:40 a.m. as entered by [licensee's contracted] on call registered nurse that read "Update to left foot- Nurses found blood in his bed near left heel. Quarter size spot to heel that looks dark purple around edges, that appears it could be a blood blister. Does not appear to have any depth to it like a pressure wound. He is responsive verbally to confused dementia at baseline. Speech mostly nonsensical. Did say 'ouch' while in chair, but once up, client not responding in any signs of

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01620	Continued From page 41	01620		

pain to touch. HHAs do not have wound cleanser, but able to cover with sterile gauze and secured with tape. Back up in bed and leg elevated on pillow. Does have some red
streaking to inner ankle partially up the side of leg. Does feel warm to touch. Warmer than right side. T 97.2 BP 108/78 P 73 O2 93% [licensee's documentation system] noted he had some spots they were watching for signs of infection on left foot. HHA explains they usually have a nurse starting at 6 a.m. but may arrive shortly after. Client now comfortable in bed and starting to sleep again. Ok to check on client 10-15 min make sure not bleeding through, and see if we can wait for nurse to arrive before next steps. At 6:30 a.m., writer calls back to HHAs [home health aides] to check status and follow up. HHAs report their nurse did not arrive so they had already updated their DON [director of nursing], DON is aware of [R14's] foot concern and status at this time. She updated HHAs that she will follow up and will be in. HHAs state client is still comfortable and resting in bed."
-August 8, 2022, at 10:24 a.m. by RN-B, "This writer looked at area on left heel. Some bleeding noted. Area is dark in color and resident having some pain associated with wound. Son Bill was called and was updated. This nurse stated that I could see if [provider] would be willing to do a referral with [Home Care agency] but it could take a few days to have this started. [R14's] son is in agreement to have this started. A call was placed to [provider] to start process."
-August 9, 2022, at 8:59 p.m. indicated, "Resident was seen by [provider name] today. [homecare services] for wound care to the blister/pressure injury on the left heel. Please reach out if we need podiatry involvement. Try to lie down 2 times per day with heels offloaded. Encourage patient to keep foot/heel elevated when in wheelchair."

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 42 - August 23, 2022, indicated, "New Order: Per [provider name], Will change wound care orders to utilize Dakins solution and cover with gauze-likely needs debridement. Due to pain with today wound care suggest tramadol 25 mg (milligrams) prior to wound care. 1)Start Tramadol 25 mg PO (by mouth) scheduled daily prior to wound care. (Discuss with [home care] wound nurse about timing). 2) Increase furosemide to 40 mg daily for 7 days then decrease back to 20 mg daily thereafter RE: edema." -August 24, 2022, read "Discussed with resident's case manager from home care agency name] a good time to schedule tramadol. Nurse stated that 0930 would be best. Tramadol scheduled for 0920 daily. [H New Order -Per [provider's name], 1) clean the wound base on the left heel with Dakins solution daily. Apply square of aquacel Ag, cover with ABD for padding protection, wrap with kling. (until wound care appointment. [home health agency name] plans to do visits M-F and [licensee] does dressing changes on Saturday and Sunday. -August 27, 2022, read "Wound care done using sterile technique. Does complain of pain when lifting leg and changing the dressing. Foul odor noted. Appears to be getting worse. -August 29, 2022, read "Resident was seen by provider name] today. Pressure ulcer posterior left heel. 3.0 cm x 3.5 cm. No infection noted. Weight needs to be kept off the ulcer site when laying down. Place a pillow under the leg so heel hangs off. Use padded vascular boot when out of bed. Home health to continue dressing changes daily. See again in one month." -September 2, 2022, at 1:51 p.m. read "Per HCA [home care aide] resident had emesis early this morning. Nurse received call from [provider name] to assess resident and get set of vitals. [Home health agency name] reported foul smell	01620		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01620	Continued From page 43	01620		

and small amount of drainage coming from wound. Resident is pale looking. All of resident's extremities are cold half wall [sic] up. Resident's lung sounds are clear and bowel sounds hypoactive. Resident sounds full phlegm in throat and is unable to clear it. Vital Signs: BP-109/74 and 111/74, P-61, T-97.8, R-22. Resident has not had any more emesis since early this morning. Resident approx. 75% of breakfast and lunch. Message left for [provider's name]."
-September 2, 2022, at 5:10 p.m. read "Per [provider's name] recommendation, resident was sent to [hospital name] ED [emergency department] for evaluation d/t [due to] low oxygen sats [saturation level] and upper and lower extremities cold to the touch. Resident left the building at 4:45 p.m. via non-emergent ambulance.
-September 3, 2022, read "Writer was able to get an update on resident. He was admitted for elevated liver enzymes. He is receiving IV antibiotics. They are running tests to try and rule out possible gall bladder issues."
-September 18, 2022, read "Tenant appears to be doing well this am shift. Writer fed him and he ate very well and took his medications as scheduled."
-September 21, 2022, read "The Resident has been fighting a foot wound presently and there have been reports of decline as well. Staff has reported that the resident almost always needs assistance with eating, has been eating smaller amounts, and has been sleeping more than normal. The resident has days where he is more awake and verbal and he still joins in for activities and exercise with the group."
-September 27, 2022, read "Resident was seen by Forsyth today. Forsyth did briefly discuss with son Paul about hospice for resident; especially if resident has more trouble swallowing. D/C [discontinue] Senna 3 times per week. Start

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 44 Senna/docusate 8.6-50 mg 1 tab 3 times a week Obtain CMP next week lab day RE: transaminitis." -September 28, 2022, read "Resident was admitted to Hospice today. RN has ordered resident a Broda chair and called Podiatry to cancel his appointment for tomorrow as she believes Hospice can manage the wound on his left heel." -September 29, 2022, read "Wound care: dressing change every other day, Hospice will do Monday and Wednesday. AL RN to do dressing change on Friday and once on the weekend. Dressings are in the room call if more are needed. Left wound care; cleanse with wound cleanser, dry with 4x4. Dampen cut Kerlix squares with Dakins and apply to wound bed, protect peri wound area, cover with white mepilex wrap with kling. Apply boot and keep elevated, keep pressure off the heel." -October 2, 2022, read "Wound care completed approximately 1.5 hours post PRN (as needed) morphine. Resident winces with removal of old dressing after having been saturated with wound cleanser for easier removal. Wound has a strong foul odor, serosanguineous drainage is visible on layers of dressing to the white mepilex foam. Cleaned with wound cleanser and treatment completed with Dakins damp 4x4 held in place with white mepilex foam and kerlix." -October 6, 2022, read "Hospice to take over dressing changes. Change will be 3 times a week. D/C previous dressing changes. Will start kerrafoam AG, cover with kerlix and boot 3x per week." -October 15, 2022, read "Wound on the left heel no longer has an odor. Center is irregularly shaped with hard yellow/brown slough tissue surrounded by deeply red tissue, especially into the plantar surface of the heel. The superior edge	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01620	Continued From page 45	01620		

is more dry in appearance, brownish pink with a distinct line of change in depth to the outer edge of the wound. Moderate amount of serosanguinous drainage on the Mepilex AG foam. Dampness through the layer of 4x4."
-November 16, 2022, read "Received fax from Hospice. - Morphine 5 mg every 8 hours for pain. Apply vascular boots to both feet at all times, except during cares."
-November 17, 2022, read "There have been no changes to the resident's foot condition."

R14's record included one document named "Weekly wound note-Non Pressure", dated August 21, 2022. This note included the following information:
- Site/location of: left heel;
- Type of wound/lesion: Other open lesion of the foot-Rashes, ulcers, cuts laceration;
- Measurements/Drainage/Tissue Appearance: size 3.0 cm (centimeters) X 3.5 cm, Depth-0.1 cm, Exudate (drainage) type-serosanguinous, Exudate amount-small, Undermining-yes, Odor-yes, Epithlialization-no, Granulation- no, Slough-no, Necrosis- no, Surrounding skin color-Normal skin color, Surrounding Tissue/Wound Edges-Peripheral tissue edema;
- Current Treatment: Cleanse wound, cover with opticel and wrap with gauze daily, Response to treatment: unchanged, Sign/Symptoms of infection-Failure to improve,
-Nutritional/Hydration Status: Ideal body weight-At IBW (ideal body weight), food intake-50-75%, Skin Turgor-Fair;
-Preventative measure/Progress: Pressure relieving interventions including elevate foot with pillow in bed so heel hangs off. Wear vascular boot when awake, and;
-Pain: Is tenant experiencing pain related to wound-Yes, Explain pain regimen- Resident has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 46 scheduled Tylenol 650 mg TID [three times daily] and has scheduled Tramadol prior to dressing change. The licensee failed to complete a RN assessment for a change in condition related to the left heel wound and lacked documentation of R14's wound condition and measurements on a weekly basis and when the licensee's nurses provided wound care on weekends. The licensee lacked documentation by the hospice agency or evidence of nursing collaboration with R14's wound care to include wound measurements and the condition of the wound. On November 30, 2022, at 9:40 a.m. the surveyor observed hospice registered nurse (RN)-J provide wound care to R14. RN-J completed measurements of R14's left heel to include a new area that measured 2.0 cm x 1.0 cm. The previous wound area measured 2.5 cm x 1.0 cm. RN-J cleansed the wound with Dakins solution, covered it with a mepi-foam Ag dressing and wrapped the dressing and foot with a kerlix wrap. She then placed vascular boot/heel protector and ensured pillows were placed to prevent pressure to the bottom of both heels. When asked about whether the licensee's nurses came to view the wound during hospice provided wound care, RN-J shook her head "no" and stated, "I don't have access to their [the licensee's electronic medical record] to document. I usually just visit with the nurse after my visit. I started faxing information, but I no longer do that. I tend to write on the marker board [pointed to a marker board on the wall in R14's room] when I want staff to know something."	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 47 On November 30, 2022, at 10:30 a.m. when asked how often she sees R14's left heel wound, RN-C stated, "I have not looked at his [R14's] heel since last week." On December 1, 2022, at 12:15 p.m. when surveyor asked about home health agency documentation, RN-B stated, "We no longer have it. When the home health agency discharges a patient, they take the record with them." At 3:00 p.m., RN-B provided one home health agency document that included three entries that only included information about R14's pain and a final entry regarding a successful discharge. No wound condition or measurements were documented. When surveyor asked for hospice documentation, RN-B stated, "We don't have anything, the nurse just chats with the RN in the memory care unit." On December 1, 2022, at 2:55 p.m. the surveyor reviewed with RN-B the one document provided as a wound assessment dated August 21, 2022, to which RN-B stated "There should have been weekly documentation about his [R14's] left heel wound by the licensee's nurses. It was an assigned task in the Service Plan Check Off. RN-B reviewed documentation on the Service Plan Check Off dated November 2022, which indicated ULP-H's initials were entered on November 5, 10, and 17, 2022, with the note "completed by hospice nurse." RN-B stated, "It appears some of the dates lined up with the team lead [ULP] to do and ULP-H likely did not realize this task needed to be completed by the [licensee's] nurse and assumed it was sufficiently managed by the hospice nurse." RN-B stated "ULP-H should have notified an RN this task needed to be completed. We dropped the ball in monitoring this nursing task. I will update the	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 48	01620		

comment section to indicate this task needs to be completed by [the licensee's] nurse." RN-B confirmed the licensee's nurses failed to complete weekly documentation of wound measurements and wound condition.

On December 1, 2022, at 4:00 p.m. RN-B presented the surveyor with R14's hospice records, and stated, "I had to request these, they were sent today, and I will start a hospice binder immediately." Upon review of hospice documentation notes included weekly entries by the hospice RN from September 29, 2022 (date of hospice admission) through November 30, 2022 (at time of survey). Each entry included wound care and wound description, drainage and various stages of healing as observed by the hospice RN with dressing changes. The entries also included the progression of R14's overall disease process.

R12
The licensee failed to complete an RN assessment for a change in condition related to emergency room visits, a diagnosis of cellulitis and following a pattern of falls.

R12's diagnoses included chronic obstructive pulmonary disease, obstructive sleep apnea, hypertension (high blood pressure), coronary artery disease (heart disease), bipolar disorder, cerebral infarction (stroke) and other signs involving cognitive functions and awareness.

R12's Service Plan dated February 22, 2022, indicated R12 received services to include medication administration, meal assistance, oxygen management, bathing, dressing and grooming assistance, exercise program, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 49 toileting/incontinence assistance. On November 28, 2022, at 10:30 a.m. during entrance conference, RN-B stated the licensee's RN completed a full comprehensive assessment prior to, or on the date of admission, after 14 days, every 90 days, with a change in condition and after a pattern of falls (two or more in a month). On November 29, 2022, at 7:05 a.m. ULP-H was observed to administer oral medications to R12 and assisted with oxygen management to include placement of oxygen nasal cannula under R12's nose at a flow rate of two liters per minute. On November 30, 2022, at 10:00 a.m. LALD-A provided the surveyor with a list of dates from the previous six months when R12's RN assessments had been completed. These dates included the dates of April 22, 2022, June 28, 2022, August 13, 2022 and October 21, 2022. R12's record lacked an assessment with a change in condition for the following occurrences: - progress note dated April 24, 2022, at 6:48 a.m. read HHA (home health aide) reaching triage around 6:40 a.m. calling to report client had pneumonia with crackles in lungs. She checked on him this morning and was naked waste down. BP 86/59 T 101.1 and not responding. Is breathing and on 02 but non-compliant. Client is DNR [do not resuscitate] but not on hospice and no clear wishes to avoid hospital or wishes for comfort care only. Advised HHA call 911 now. Will update family upon EMS [emergency medical services] update. 7:10 called back to facility for update but unable to reach. 7:30 HHA updates client did transfer to [hospital name]. Writer updates sister [name] with status and she will f/u	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 50 with hospital status. HHA updating DON [director of nursing] per policy. Then a note April 24, 2022, at 10:35 p.m. read came back from the emergency room. Nothing told to writer. No med [medications] no new orders. - progress note dated September 12, 2022, at 2:21 a.m. read caregiver [name] calling reporting the resident had an unwitnessed fall. Reports he was found by the bedside is more confused, not responding appropriately with complaints of left thigh and left arm pain. Caregiver reporting the resident can't sit upright for a sling to be placed to assist the resident back to bed. Advised with pain, confusion and not responding appropriately to call 911 for EMS to transport resident to the ER for evaluation. T-97.0, R-14, BP 145/92, Oxygen 99%, pulse 49. Sister [name] has been updated and will follow up with the hospital. Another note dated September 12, 2022, at 1:06. p.m. read resident returned around 0920 to facility. Resident then was taken back to ER to have IV removed that was still in arm. Resident diagnosed with cellulitis of left lower leg. Start Keflex monohydrate 500 MG 4 times a day for 10 days RE: Cellulitis of left lower leg. -progress note dated September 14, 2022, at 3:11 a.m. read caregiver [name] calling reporting the resident is completely out of it. Reports he will not respond to his name and is only mumbling. P-49, BP 132/65, T-97.8. Staff to send resident to the ER for further evaluation. Sister [name] has been notified and is aware of the plan. Will follow up with the hospital. Another note dated September 14, 2022, at 11:54 a.m. read 'resident returned back to [facility name] accompanied by sister [name] with diagnosis of drowsiness and general medical. Follow up with [provider name]. Call to schedule appointment as needed. Continue your medications as previously prescribed. Return to ER if worse.'	01620		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 51 The licensee failed to complete an RN assessment after R12's progress notes indicated a pattern of falls as follows: -November 12, 2022-put self to floor to get something from under the bed -November 15, 2022-unwitnessed fall, no injuries -November 17, 2022- fall from the chair, no injuries -November 19, 2022- unwitnessed fall, increased blood pressure, seen onsite by paramedics (who were on site), no injuries -November 27, 2022-witnessed fall from chair, no injuries On December 2, 2022, at 8:30 a.m. RN-B verified the need for assessments to be completed after the change in conditions evidenced by emergency room visits, hospitalizations, or a pattern of falls. Timely assessments On November 28, 2022, at 10:30 a.m. during the entrance conference, RN-B stated comprehensive assessments are completed at least every 90 days and with a change in condition. R13 R13's diagnoses included vascular dementia without behaviors, Alzheimer's disease, Type 2 Diabetes, seizure disorder, hypertension, and heart disease. R13's Service Plan dated August 19, 2022, indicated R13 received services that included medication administration, weekly bathing/showering, dressing/grooming, blood glucose monitoring, injections, exercise program,	01620		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 52	01620		

assistance with transfers, meal assistance and toileting and incontinence assistance.

On November 29, 2022, at 7:40 a.m. ULP-G was observed to complete a blood glucose check, provide an insulin injection, and administer oral medications.

R13's record included RN assessments with the following dates: January 3, 2022, April 1, 2022, and June 27, 2022. Each assessment lacked the required content of a full RN assessment.

In addition, R13's record lacked evidence of ongoing reassessment and monitoring since June 27, 2022.

R6
R6 was admitted to the comprehensive license on July 22, 2013, and was admitted to the Assisted Living Facility (ALF) license on August 1, 2021.

R6's Service Plan dated February 22, 2022, identified he received services including medication administration, toileting and incontinence care, dressing, grooming, bathing, and applying TED (thrombo embolic deterrent) stockings (compression stockings to reduce swelling and improve circulation).

R6's record identified comprehensive assessments had been completed on March 8, 2022, June 10, 2022 (94 days since previous assessment), and October 25, 2022 (137 days since the previous assessment.)

R15
R15 was admitted to the facility on May, 11, 2021, and began receiving services under the ALF license on August 1, 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 53 R15's Service Plan dated August 23, 2022, identified he received services including urinary catheter care, dressing, and grooming. R15's record identified comprehensive assessments had been completed on February 9, 2022, May 27, 2022 (107 days after the previous assessment), June 13, 2022, and October 19, 2022 (128 days after the previous assessment.) On December 1, 2022, at 4:00 p.m. RN-B stated she would look for more complete "NEW assessments" as a new assessment template had been created to encompass all the required elements and many residents still needed to be updated. An assessment was then provided dated December 1, 2022. The licensee's Comprehensive Assessment Schedule policy dated August 2022, indicated ongoing client monitoring and reassessment was to be completed at least every 90 days and changes in client condition was to be completed as indicated.	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The	01640		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 54 facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to include the treatment of vascular boots and hospice services for one of five (R14) records reviewed. Additionally the Service Plan dated August 16, 2022, lacked the licensee and designated representative signatures. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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: R14's diagnoses included vascular dementia with behavioral disturbance (a type of dementia caused by conditions that damage blood vessels	01640		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 55	01640		

and block blood flow to the brain causing cognitive changes with thinking and behavior), lymphoma and chronic kidney disease.

R14's Service plan (unsigned) dated August 16, 2022, indicated services included medication management, toileting/incontinence assistance, bathing assistance, meal assistance, wound management, skin care and safety checks. The Service Plan lacked the treatment of vascular boots and hospice services, and lacked signatures or other authentication by the facility and by the resident documenting agreement on the services to be provided.

R14's record indicated a verbal order for the treatment of vascular boots as follows:
- October 13, 2022, OK to use EZ stand (mechanical lift) for transfers, make sure vascular boot is on left foot at all times. Make sure feet are positioned properly in the stand to avoid injury,
- November 16, 2022, Apply vascular boots to both feet, keep on at all times except with cares.

R14's record indicated the initiation of hospice services on September 28, 2022.

On November 29, 2022, at 7:40 a.m. the surveyor observed unlicensed personnel (ULP)-I administer oral medications, wash R14's face, provide oral care, repositioning in bed and ensured vascular boots/heel protectors were in place.

On December 1, 2022, at 3:10 p.m. registered nurse (RN)-B stated RN-C was looking to see when the August 16, 2022, service plan was sent to R14's designated representative for a signature as she thought she may have kept an email account of the communication. No further

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 56 information was provided. RN-B verified R14's service plan lacked the updated services of the vascular boots and hospice. The licensee's Service Plan policy dated April 2022, indicated any changes to the service plan or agreement must be in writing and must be signed by the client or the client's responsible person and the RN. The service plan must be revised, if needed, based on the results of required client monitoring and/or reassessments. The service plan and any revised service plans must be entered into the client's record, including notice of a change in a client's fees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01700	Continued From page 57	01700		

address these issues.
(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the licensee failed to have a medication assessment for four of four residents (R6, R12, R13, and R14) that included interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications to prevent diversion of medications.

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:

R6, R12, R13, and R14's medication assessment lacked interventions needed in management of

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

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SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01700	Continued From page 58	01700		

medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.

R6's "Medication/Treatment/Therapy Management Plan" integrated in the Annual/Change in Condition Assessment dated June 10, 2022, failed to identify risk for diversion of medications and interventions to manage the residents's medication to prevent diversion of medications.

R12's "Medication/Treatment/Therapy Management Plan" integrated in the NEW Nursing Assessment dated October 21, 2022, failed to identify risk for diversion of medications and interventions to manage the residents's medication to prevent diversion of medications.

R13's "Medication/Treatment/Therapy Management Plan" integrated in the Comprehensive assessment dated June 27, 2022 , failed to identify risk for diversion of medications and interventions to manage the residents's medication to prevent diversion of medications.

R14's "Medication/Treatment/Therapy Management Plan" integrated in the NEW Nursing Assessment dated August 29, 2022, failed to identify risk for diversion of medications and interventions to manage the residents's medication to prevent diversion of medications.

The licensee's Medications & Treatments policy dated March 2021, identified "The Medication and Treatment Management Plan will identify

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

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01700	Continued From page 59 measures for preventing a diversion of medications by tenants or others who have access to the medication." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor and reassess the resident's medication management services at least annually for one of five residents (R13) receiving medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01710	Continued From page 60 R13's Service Plan dated August 19, 2022, indicated R13 received services including medication administration, blood glucose monitoring, and injections. R13's diagnoses included vascular dementia without behaviors, Alzheimer's disease, Type 2 Diabetes, seizure disorder, hypertension, and heart disease. R13's Medication Administration Sheet (MAR) dated November 2022, indicated R13 received medications including one for seizure disorder, four for diabetes, two for heart disease, two for hypertension, two supplements, one for cholesterol, one for glaucoma, and one for mild pain. On November 29, 2022, at 7:40 a.m. unlicensed personnel (ULP)-G was observed to complete a blood glucose check, provide an insulin injection, and administer oral medications. R13's document labeled Annual/Change in Condition Assessment dated November 6, 2021, included the following content of a medication assessment/plan: -Can state name of medication-No -Can read bottle for name and dosage-Yes -Knows when to take each medication-No -Remembers when to take each medication on time-No -Able to open containers-No -Able to pour liquids-NA -Able to administer eye drops-No -Able to administer ear drops-NA (not applicable) -Able to administer inhaled medications-NA -Can administer injections-No -Medication Management-Medication administration	01710		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

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01710	Continued From page 61	01710		

-Medications and supplies are ordered from the following vendors-(pharmacy name)
-Summary of how medications are supplied and delivered-Tenant on cycle fill, nurse to order non-cycle fill medications when needed.
-Who is responsible for reordering medications and or supplies-Nurse
-Storage of medication-Locked in apartment
-Tenant specific instruction-Refer to MAR for tenant on medication management
-Documentation-Refer to MAR
-Person to notify with problems/concerns with medication management-RN
-Change in medication management-No
-Medication review-Reviewed indications, side effects, contraindications, allergic reactions and diversion with family/responsible party
-Summary of medication management services-staff to administer all medications

R13's document labeled Comprehensive Assessment dated January 3, 2022, included only one line regarding a medication review which read "Medications reviewed, no changes have been made this quarter."
R13's document labeled Comprehensive Assessment dated June 27, 2022, in Medication section included one line which read "Medications reviewed, no changes have been made this quarter, Last change May 7, 2021."

On December 2, 2022, at 9:00 a.m. RN-B provided surveyor with a document labeled NEW Nursing Assessment dated December 1, 2022 (after the survey had been initiated), which included medication plan and assessment but was not completed within the required annual timeline. RN-B stated they were still catching residents up with the new nursing assessment template which included the medication plan and

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01710	Continued From page 62 assessment. RN-B verified R13's medication plan and assessment had not been fully reviewed in over a year. The licensee's Medication and Treatment policy dated August 2021, indicated the Medication and Treatment Management Plan will be completed for all tenants receiving services prior to initiating services, annually and with a change in condition. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 63	01730		

tasks that may be delegated to unlicensed personnel;
(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and
(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.
(b) The medication management record must be current and updated when there are any changes.
(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the documentation of special instructions for two of five residents (R12, R14) with medications provided.

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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

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01730	Continued From page 64	01730		

R12
The licensee failed to instruct unlicensed personnel (ULP) to monitor for bruising or bleeding related to the use of Xarelto (a blood thinning medication).

R12's Service Plan dated February 22, 2022, indicated R12 received services to include medication administration, meal assistance, oxygen management, bathing, dressing and grooming assistance, exercise program, and toileting/incontinence assistance.

R12's diagnoses included chronic obstructive pulmonary disease, obstructive sleep apnea, hypertension (high blood pressure), coronary artery disease (heart disease), bipolar disorder, cerebral infarction (stroke) and other signs involving cognitive functions and awareness.

R12's Medication Administration Record (MAR) dated November 2022, included two medications for allergies, one supplement, one for cognitive decline, three for bipolar/mood/hallucinations/paranoia, three for pain, one for thyroid, two for high blood pressure, one for blood thinning, one for gastroesophageal reflux, two for COPD, one for cholesterol, two for constipation, and one for skin rash.

On November 29, 2022, at 7:05 a.m. ULP-H was observed to administer oral medications to R12 and assisted with oxygen management to include placement of oxygen nasal cannula under R12's nose at a flow rate of two liters per minute.

R12's record included an order dated July 26, 2022, for Xarelto 20 mg (milligrams), once daily orally every day with supper, as a blood thinner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 65 for the diagnosis of atrial fibrillation (a condition where the heart beats erratically and can increase the risk of blood clots and stroke). R12's progress notes indicated R12 had multiple falls with dates that included: -May 25, 2022- unwitnessed fall, no injuries -June 24, 2022- no injuries -July 25, 2022-unwitnessed fall, no injuries -September 12, 2022- fall, resident disoriented with pain with left thigh and left arm; transported to Emergency room, returned with the diagnosis of cellulitis (infection) of the left lower leg. -October 6, 2022- tipped recliner backwards, uncertain of cause, no injury -October 20, 2022-fall from chair level, missed the chair and landed on the floor. No injuries -November 12, 2022-put self to floor to get something from under the bed -November 15, 2022-unwitnessed fall, no injuries -November 17, 2022- fall from the chair, no injuries -November 19, 2022- unwitnessed fall, increased blood pressure, seen onsite by paramedics (who were on site), no injuries -November 27, 2022-witnessed fall from chair, no injuries. The licensee failed to document specific instructions related to monitoring for bleeding and bruising associated with the medication, Xarelto, especially in light of R12's frequent falls. On December 2, 2022, at 9:40 a.m. licensed assisted living director (LALD)-A verified the lack of instruction related to monitoring for bleeding or bruising and would edit R12's information to include this. R14	01730		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 66 R14's Service plan (unsigned) dated August 16, 2022, indicated services included medication management, toileting/incontinence assistance, bathing assistance, meal assistance, wound management, skin care and safety checks. R14's diagnoses included vascular dementia with behavioral disturbance (a type of dementia caused by conditions that damage blood vessels and block blood flow to the brain causing cognitive changes with thinking and behavior), lymphoma and chronic kidney disease. On November 29, 2022, at 7:40 a.m. the surveyor observed ULP-I administer oral medications, wash R14's face, provide oral care, repositioning in bed and ensured vascular boots/heel protectors were in place. R14's MAR dated November 2022, indicated he received five medications for anxiety/mood, one for edema, two for constipation, two for pain, one for urinary retention, one for excess secretions at end of life, one for ears, one for hemorrhoids, and two for skin. R14's record included an order dated September 28, 2022, as a new hospice medication, lorazepam 0.5 mg by mouth/sublingually (under the tongue) as needed for shortness of breath, nausea, or anxiety. If relief not sufficient, may repeat dose up to four times in four hours. Do not exceed 2 (two) mg in four hours. R14's record also included an order dated September 27, 2022, for Buspar 10 mg once daily as needed for anxiety. The licensee failed to provide documentation of specific resident instructions relating to the administration of the as needed lorazepam and	01730		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01730	Continued From page 67 Buspar, and lacked the description of what symptoms of R14's anxiety would prompt the use of an as needed medication. On December 1, 2022, at 3:15 p.m. registered nurse (RN)-B stated she had not thought to distinguish the two medications and clarify which would be used and when. RN-B stated she would work with the memory care RN and have this clarified right away. The licensee's Medication and Treatment policy dated August 2021, indicated The Medication and Treatment Management Plan will be completed for all tenant's receiving services prior to initiating services, annually and with a change in condition. The Medication and Treatment Management Plan will describe the medication or treatment service provided. A description of storage of medications and documentation of tenant specific instructions for medications or treatments. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any	01760		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01760	Continued From page 68 follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriber orders were transcribed as ordered for one of five residents (R12) observed for medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R12's MAR dated November 2022, lacked the route for administration for acetaminophen. R12's Service Plan dated February 22, 2022, indicated R12 received services to include medication administration. R12's acetaminophen order dated July 26, 2022, indicated acetaminophen 500 mg tabs (tablets), give two tablets PO (orally) three times a day. On November 29, 2022, at 7:05 a.m. ULP-H was observed to administer oral medications to R12 and assisted with oxygen management. R12's MAR dated November 2022, indicated R12	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 69 received acetaminophen 500 mg three times daily from November 1-28, 2022, but lacked the route of administration. On December 2, 2022, at 12:30 p.m. RN-B confirmed R12's MAR lacked the route of acetaminophen. RN-B stated she would have someone fix it right away. The licensee's Medications & Treatments policy dated March 2021, identified "Content of medication orders must contain the name of the drug, dosage, frequency, route, indication and directions for use." When administering medications, staff were to "follow the 6 rights: · Right person · Right medication · Right time · Right route (i.e. by mouth, eye drops, to the skin) · Right dose (i.e. how many milligrams, drops) · Right chart/record to document that the medication was taken" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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	01820		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01820	Continued From page 70 by: Based on observation, interview, and record review the licensee failed to ensure signed prescriber's orders for medications for one of five residents (R14). 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: R14's Service Addendum to the Assisted Living Contract (unsigned) dated August 17, 2022, indicated services included medication management. R14's record included Verbal orders given by the provider's RN to licensee's RN but lacked follow up physician signatures: -September 29, 2022, Discontinue scheduled Tramadol at 9:30 a.m., will use PRN (as needed) MS (morphine sulfate) prior to dressing changes. Discontinue: PRN Ativan tablets, will use hospice solutab Ativan orders. -September 29, 2022, Tylenol Extra Strength 500 mg (milligrams) oral tablet, take 2 (two) tablets orally 3 (three) times daily. Discontinue: effective September 29, 2022, Tylenol Regular Strength 325 mg oral tablet: take 2 (two) tablets 3 times daily. Discontinue: effective September 29, 2022, Vitamin B-12 1000 mcg (micrograms) oral tablet taken orally once daily. -November 3, 2022, Abilify (aripiprazole) 10 mg	01820		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01820	Continued From page 71	01820		

tablet; take one tablet orally once daily. Discontinue: effective November 3, 2022, aripiprazole 15 mg oral tablet; orally daily.
-November 4, 2022, Abilify 5 (five) mg oral once a day, decrease to 5 (five) mg. Discontinue: effective November 4, 2022, Abilify 10 mg oral tablet daily.

R14's November 2022, medication administration record (MAR) indicated the following medications had been administered without current signed physician orders with R14's record only containing verbal orders as taken by licensee's nurse:
-acetaminophen 500 mg (milligrams), two tablets, three times daily. Given November 1-28, 2022.
-aripiprazole 15 mg, take 0.5 tablet by mouth every day. Given November 1-7, 2022.
-aripiprazole 5 mg take one tablet by mouth every day. Given November 8-28, 2022.
-acetaminophen 325 mg take 2 (two tablets) orally daily as needed. Given on November 12, 2022.

On December 1, 2022, at 3:00 p.m. RN-B provided verbal orders for the above noted medications and stated, "I thought as long as we had a verbal order, we were fine. Signed provider orders are hard to get. I will reach out to the provider to obtain signed orders for these. I will also educate our nursing team and edit our process to ensure signed orders follow verbal orders and close the loop on orders."

The licensee's Medication policy dated March 2021, indicated the RN is responsible for assuring a written prescriber's order must be obtained for any treatment/medication administration provided to a tenant. The order must be dated, contain the name of the medication/treatment, dosage,

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

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SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01820	Continued From page 72 frequency, route, indication, signed by the prescriber and must be current and consistent with the nursing assessment. Verbal orders received from a prescriber must have the RN/LPN record and sign the order and forward the written order to the prescriber for the prescriber's signature. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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 securely locked in substantially constructed compartments and permitted only authorized personnel to have access. 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).	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01880	Continued From page 73 The findings include: On November 28, 2022, at 12:30 p.m. during the facility tour, the surveyor observed medication cards sitting on a desk in an office area. The door to this area was unlocked and open. Registered nurse (RN)-B stated they were waiting for the pharmacy to pick them up as they were being returned. RN-B further indicated they should have been stored securely. The medications in bubble backs, left out in the open were: R1 -fish oil capsule 100 mg (milligrams) 28 capsules (supplement) -Tab-a-Vite 28 tabs (supplement) -vitamin B-12 1000 mcg (micrograms) 28 tabs (supplement) -Wes Tab 28 tabs (supplement) R10 -Aspirin 325 mg 28 tabs (heart health) -atorvastatin 80 mg 28 tabs (cholesterol)\ -memantine 5 mg 56 tabs (Alzheimer's disease) R2 -venlafaxine 37.5 mg 28 tabs (depression) -venlafaxine 75 mg 28 tabs R3 -escitalopram 10 mg 28 tabs (depression) R13 The licensee failed to securely store R13's insulin flex pens. R13's diagnoses included vascular dementia without behaviors, Alzheimer's disease, Type 2 Diabetes, seizure disorder, hypertension, and heart disease. R13's Service Plan dated August 19, 2022, indicated R13 received services that included	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 74 medication administration, blood glucose monitoring, and injections. On November 29, 2022, at 7:40 a.m. unlicensed personnel (ULP)-G was observed to complete a blood glucose check, provide an insulin injection, and administer oral medications. On November 29, 2022, at 10:20 a.m. the surveyor observed two insulin pens (Basaglar Flexpen 100 units(u)/milliliter(ml) and Novolog Flexpen 100 u/ml in the mini refrigerator door in R13's room of the memory care unit. The insulin pens were not securely locked and stored. On November 29, 2022, at 11:30 a.m. RN-B stated she had not thought about the need to lock the insulin flex pens stored in the mini refrigerator and all of the insulins for residents were stored this way. RN-B stated she would work with administration to either store the refrigerated insulin flex pens in the nurse's office refrigerator or determine a way to secure them in the resident's mini refrigerator. The licensee's Medication/Treatment policy dated March 2021, indicated medications managed inside a tenant's private "living space" must be securely locked and substantially constructed compartments and permit only authorized personnel to have access. They may be a locked drawer, cabinet, etc. the keys will be stored in a secured cabinet when not in use by authorized personnel. No further information was provided. TIME PERIOD FOR CORRECTION: seven (7) days	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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01890	Continued From page 75	01890		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened and had a pharmacy label for five of five residents' (R6, R4, R5, R11, and R13) medication cupboards. 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: R6 On November 29, 2022, at 6:50 a.m. unlicensed personnel (ULP)-D was observed administering an inhaler to R6. R6 had an albuterol inhaler with a small pharmacy label that had R6's name, the name of the medication and the prescription number. There was no corresponding packaging in the cupboard with a full prescription label. There was no open date marked on the inhaler.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 76	01890		

R4
On November 29, 2022, at 7:30 a.m. ULP-D was observed administering medications to R4. A review of the locked medication cabinet in R4's room identified the following
-latanoprost 0.005% (glaucoma) eye drops with no open date marked on the bottle;
-melatonin (sleep) 5 mg (milligram) gummies - no pharmacy label with an expiration of September 2022;
-gavilax powder (constipation) powder with an expiration date of August 24, 2022.

On November 29, 2022, at 7:33 a.m. ULP-D stated that the eye drops should have been marked with the date opened and expired medications should have been removed from the cabinet. She was unsure who checked medication cupboards for expirations, but believed it was the team lead or the registered nurse (RN). ULP-D brought the expired medications to RN-C who stated the PRNs (as needed medications) get missed since they are not always used and staff were to check for outdates when they administered the medications. Eye drops should have been marked with the open date, but the bottle had an expiration date of October 30, 2023. Once opened, it has so many days that it is good. Staff were trained to go by the use by date. RN-C stated she would have to look up how long the latanoprost was good after opened.

R5
On November 29, 2022, at 8:00 a.m. ULP-D administered medications to R5. A review of the locked medication cupboard in R5's room identified the following:
-Systane solution with a small label identifying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
01890	Continued From page 77	01890		

only with R5's name, Systane solrx, and the prescription number. There was a date of "August 12," the year only the number "2" was legible.
-Genteal gel 0.3% there were three tubes
1. The first tube was almost empty, there was no pharmacy label on the tube, no open date marked on it, and there was no cap on the tube. The tube was in a bag with a full prescription label.
2. The second tube was sitting on the shelf, not in a bag. It had a small label with only R5's name, the name of the medication and the prescription number. There was no open date on the tube. The prescription number matched the prescription number of the bag the first tube was in.
3. The third tube had a small label with R5's name, the name of the medication, and the prescription number. There was no open date on the tube and there was no corresponding package with a full pharmacy label. The prescription number was not the same as the bag the first tube was in.
- Refresh Relieva PF with no pharmacy label, and no open date marked on the bottle
-ear drops 6.5% solution with no pharmacy label.
ULP-D stated the medications should be stored in the bag with the full pharmacy labels and should be marked when opened.

R11
A review of locked medications cupboard in R11's room identified a NovoLog FlexPen insulin pen with no pharmacy label on the pen.

On November 29, 2022, at 8:28 a.m. RN-B stated the staff were trained in medication training that the eye drops were only good for one month and that medications should be marked when they are opened and disposed of after one month. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

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01890	Continued From page 78 was unaware of the variable number of days medications were good for after they were opened and stated the facility trained one month after opening. R13 The licensee failed to ensure proper labeling for one basaglar insulin flexpen as stored in R13's medication cupboard. R13's Service Plan dated August 19, 2022, indicated R13 received services that included medication administration, blood glucose monitoring, and injections. R13's MAR dated November 2022, indicated he received basaglar 100 units/milliliter (ml) subcutaneously daily at bedtime for diabetes. On November 29, 2022, at 7:40 a.m. ULP-G was observed to complete a blood glucose check, provide an insulin injection, and administer oral medications. On November 29, 2022, at 10:20 a.m. the surveyor and ULP-G reviewed the contents of R13's medication cupboard and mini-refrigerator. The surveyor observed one unlabeled insulin flex pen (Basalog) which contained only an "opened" label. The flex pen lacked a label to indicate the resident's name, the dose and route of administration. ULP-G showed the surveyor that the extra flex pens (basaglar and novolog) were kept in the mini refrigerator until needed. The surveyor observed one basaglar flex pen in a labeled zip-lock bag and one novolog flex pen in a separate labeled zip lock bag in the mini refrigerator door. On November 29, 2022, at 11:30 a.m. RN-B	01890		

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01890	Continued From page 79 stated she was not aware the basaglar flex pens were not individually labeled but understood the pharmacy sent the insulin in a tabled zip lock bag. RN-B stated she would work with the pharmacy to obtain additional labels or an additional labeled bag to ensure the pens are properly labeled when removed from the mini refrigerator and put into use and then stored in the resident's medication cupboard. The licensee's Medications & Treatments policy dated March 2021, identified the following -"If the label cannot be read or if the MAR and the label do not match, stop and call the RN for instructions. The directions on the label and the MAR should be the same." -"Any medication received from pharmacy in manufacturer box, bag, or container, should be kept in the original packaging. Once opened for use medication should be labeled with the specific date of first use." -"Medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). Store medications in a cool, dry place (25°C/77°F) unless specified to be refrigerated. -The expiration date of a product can change once it is opened . -Medications managed inside a tenant's private "living space" must be securely locked and substantially constructed compartments and permit only authorized personnel to have access. They may be a locked drawer, cabinet, etc. The keys will be stored in a secured cabinet when not in use by authorized personal. - Medication 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 date. This will coincide with the medication audit check labels	01890		

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01890	Continued From page 80 etc. -Keep all medications in original container in which they were dispensed." The policy included a Storage and Expiration grid that identified the following; -"Eye, ear, nose drops or ointments (sterile) - 28 days from date when opened" -"Xalatan [latanoprost]: refrigerate until opened - 42 days after opened -"Insulin - Unopened, store in refrigerator, expiration per manufacturer date - Once opened, vial/pen expires 4 weeks (28 days) after opened " -"Inhalers - Albuterol: 3 months" NovoLog FlexPen manufacturer directions dated February 2015, identified "The NovoLog FlexTouch Pen you are using should be thrown away after 28 days, even if it still has insulin left in it." Basaglar KwikPen instructions for use dated July 2021, identified "Throw away the Pen you are using after 28 days, even if it still has insulin left in it." Latanaprost manufacturer directions dated September 16, 2014, identified "must be used within 28 days after opening the bottle. Discard the bottle and/or unused contents after 28 days." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the	01910		

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01910	Continued From page 81 resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for two of five residents (R4 and R12). 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:	01910		

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01910	Continued From page 82 R4 On November 29, 2022, at 7:30 a.m. unlicensed personnel (ULP)-D was observed administering medications to R4. A review of the locked medication cabinet in R4's room identified the following: -melatonin (sleep) 5 mg (milligram) gummies - no pharmacy label with an expiration of September 2022; and -gavilax powder (constipation) powder with an expiration date of August 24, 2022. On November 29, 2022, at 7:33 a.m. ULP-D stated expired medications should have been removed from the cabinet. She was unsure who checked medication cupboards for expirations, but believed it was the team lead or the registered nurse. ULP-D brought the expired medications to registered nurse (RN)-C who stated the PRNs (as needed medications) get missed since they are not always used, and staff were to check for expiration dates when they administered the medications. R12 On November 29, 2022, at 7:15 a.m. the surveyor and ULP-H reviewed the contents of R12's medication cupboard and observed a bottle of gavilax with an expiration date of August 2022. On November 30, 2022, at 11:50 a.m. RN-B stated the nurses in memory care usually monitor the expiration dates with their routine review of medication supplies. The licensee's Medication/Treatment policy dated March 2021, indicated expired medications managed by the home care provider will disposed of according to the accepted practices of the Minnesota Board of Pharmacy and the labels	01910		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01910	Continued From page 83 from the containers will be destroyed. Upon disposition, the comprehensive home care provider must document in the tenant's record the disposition of the expired medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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 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	01940		

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01940	Continued From page 84 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of four residents (R14) 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: R14's Treatment plan (found in the document "NEW Nursing Assessment" dated October 21, 2022), lacked the treatment of vascular boots. R14's Service plan (unsigned) dated August 16, 2022, indicated services included medication management, toileting/incontinence assistance, bathing assistance, meal assistance, wound management, skin care and safety checks.	01940		

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01940	Continued From page 85 R14's diagnoses included vascular dementia with behavioral disturbance (a type of dementia caused by conditions that damage blood vessels and block blood flow to the brain causing cognitive changes with thinking and behavior), lymphoma and chronic kidney disease. On November 29, 2022, at 7:40 a.m. the surveyor observed ULP-I administer oral medications, wash R14's face, provide oral care, repositioning in bed and ensured vascular boots/heel protectors were in place. R14's progress note dated August 8, 2022, indicated new evidence of a left heel wound. R14's progress note dated August 29, 2022, indicated the instruction "Use padded vascular boot when out of bed." Furthermore, a progress noted dated November 16, 2022, read, "Received fax from hospice. Apply vascular boots to both feet at all times, except during cares." R14's NEW Nursing Assessment dated October 21, 2022, in the section identified as treatments, indicated for skin care, "Creams, lotion, wound care. Hospice provides wound care and supplies M-W-F [Monday, Wednesday, Friday]." Additionally, in the section identified as Summary of Treatments or Therapy Services, "nurse has reviewed with the resident and or resident's family the indication, current use of treatment/therapy, level of assistance and possible complications-wound care provided 3 [three] times a week by hospice." The assessment lacked evidence of the vascular boots and instructions for the ULP. On December 1, 2022, at 12:15 p.m. RN-B verified R14's treatment plan lacked the treatment	01940		

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01940	Continued From page 86 of vascular boots and lacked instructions for ULP to follow and for when ULP should notify nursing. The Licensee's Medication & Treatment policy dated March 2021, identified "There must be an individualized treatment plan that includes the following: 1. A statement of the type of services that will be provided. This is included on the service plan and is signed by the client. 2. Documentation of specific client instructions relating to the treatment or therapy administration. A therapy/treatment instruction form is located in the client's apartment or in their chart. 3. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel. This information is identified on the service agreement. 4. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. 5. All treatment/therapy to be administered as prescribed and documented. The treatment or therapy management record must be current and updated when there are any changes or reviewed during 90 day supervisory visits. Changes to be documented on service agreement, service schedule, and a progress note is to be recorded in client chart." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments	01960		

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01960	Continued From page 87 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 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 services were documented for one of four residents (R14). 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: R14 R14's record lacked the treatment documentation of vascular boots. R14's Service plan (unsigned) dated August 16, 2022, indicated services included medication management, toileting/incontinence assistance, bathing assistance, meal assistance, wound	01960		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

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01960	Continued From page 88 management, skin care and safety checks. On November 29, 2022, at 7:40 a.m. the surveyor observed unlicensed personnel (ULP)-I administer oral medications, wash R14's face, provide oral care, repositioning in bed and ensured vascular boots/heel protectors were in place. R14's Progress note dated August 8, 2022, indicated evidence of a new wound on R14's left heel. R14's progress note dated August 29, 2022, indicated the instruction "Use padded vascular boot when out of bed." Furthermore, a progress noted dated November 16, 2022, read, "Received fax from hospice. Apply vascular boots to both feet at all times, except during cares." R14's Medication Administration Record (MAR) and Service Check-off List dated November 2022, both lacked evidence of documentation with the treatment of vascular boots. On December 1, 2022, at 12:15 p.m. RN-B verified R14's record lacked documentation of the treatment of vascular boots. The licensee's Medications and Treatment policy dated March 2021, read Documentation of specific client instructions relating to the treatment or therapy administration, a therapy/treatment instruction form is located in the client's apartment or in their chart. All treatment/therapy to be administered as prescribed and documented. The treatment or therapy management record must be current and updated when there are any changes or reviewed during 90 day supervisory visits. Changes to be	01960		

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01960	Continued From page 89 documented on service agreement, service schedule, and a progress note is to be recorded in client chart. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01960		
02110 SS=D	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;	02110		

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02110	Continued From page 90 (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 ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for two of three residents (R13, R14) 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: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2022. R13 and R14's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include:	02110		

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SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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02110	Continued From page 91 - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On December 1, 2022, at 3:00 p.m. licensed assisted living director (LALD)-A stated a copy of these policies had been sent out to R13 and R14's designated representatives a couple of times, with the most recent mailing being a couple weeks ago. LALD-A was unable to provide confirmation/documentation of these attempts to gain signatures of receipt. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-One	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02110	Continued From page 92 (21) days	02110		
02240 SS=D	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or	02240		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

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02240	Continued From page 93	02240		

complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint.
(d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for two of five residents (R6 and R15).

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:

R6 was admitted to the Assisted Living Facility with Dementia Care licensee on August 1, 2021.

On November 29, 2022, at 6:50 a.m. unlicensed personnel (ULP)-D was observed administering medication and applying Tubigrip (provides firm support for sprains, strains and swelling) to

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02240	Continued From page 94 bilateral lower legs. R6's record lacked evidence of a written acknowledgement the resident received the assisted living bill of rights. R14 R14 began receiving assisted living with dementia care services on August 1, 2021. On November 29, 2022, at 7:40 a.m. the surveyor observed unlicensed personnel (ULP)-I administer oral medications, wash R14's face, provide oral care, repositioning in bed and ensured vascular boots/heel protectors were in place. R14's Service Addendum to the Assisted Living Contract (unsigned) dated August 17, 2022, on page 7 (seven) included a designated lined area indicating the receipt of the Minnesota Home Care Bill of Rights. This line was neither "checked" nor initialed, and the document was not signed or dated by the licensee or R14's designated representative. On December 1, 2022, at 3:00 p.m. LALD-A stated the Service Addendum, Bill of Rights, and dementia care policies had been sent out to R6 and R14's designated representatives. No return signed receipt of this document has been received. LALD-A was unable to provide a date or email verification with this document being sent. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 95	02310		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for three of three residents (R14, R15, R9) with bed rails. This resulted in an immediate order issued on November 30, 2022, at approximately 4:07 p.m.. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R14 R14 began receiving services on July 17, 2015, under the Comprehensive home care license. R14's Service plan dated March 1, 2022, indicated services included medication management, toileting/incontinence assistance, bathing assistance, meal assistance and safety checks.	02310		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

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SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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02310	Continued From page 96 R14 began receiving services under the Assisted Living Facility with Dementia Care (ALFDC) license on August 1, 2021. R14 resided in the dementia care part of the building. On November 29, 2022, at 7:40 a.m. surveyor observed unlicensed personnel (ULP)-I administer oral medications, wash R14's face, provide oral care, repositioning in bed and ensured vascular boots/heel protectors were in place. R14 was lying in a hospital bed with bilateral upper bed rails in the upright position. On November 29, 2022, at 11:30 a.m. surveyor requested registered nurse (RN)-B provide R14's records to include bed rail assessment, bed rail measurements, and risk verses benefits discussion. On November 30, 2022, at 9:20 a.m. licensed assisted living director (LALD)-A stated she was not aware R14 had a hospital bed with bed rails. LALD-A verified there was no evidence of a bed rail assessment, measurements or risks verses benefits in R14's record. LALD-A stated she wanted to go look at the bed for herself. Surveyor accompanied LALD-A and registered nurse (RN)-B to R14's room and observed R-14 lying in a hospital bed which included two upper bed rails. Both bed rails were observed in the upright position. RN-B stated she was not aware R14 had a hospital bed and would check with RN-C to determine whether an assessment and measurements had been completed. On November 30, 2022, at 9:40 a.m. hospice registered nurse (HRN)-J was observed to complete a dressing change for R14's left heel wound. HRN-J stated R14 started hospice services on September 28, 2022, and HRN-J	02310		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 97	02310		

stated she ordered R14's hospital bed on September 29, 2022, due to R14's previous bed being broken.

On November 30, 2022, at 10:15 a.m. RN-B returned to R14's room and stated RN-C was aware of the hospital bed but had not completed an assessment, measurements of the side rail openings, nor a risk verses benefits review with R14's resident representative. RN-B began to measure the hospital bed rails. RN-B referenced a bed rail document she stated she used as a guide for measurements and asked for clarification about the zones to be measured. RN-B stated she had only been measuring zones one, two, and three in the past and was not aware of the requirement to measure zone four. RN- B created a drawing of R14's bed rails and completed measurements to include zone one at 2.75 inches with each opening, zone two at zero (0) inches with bottom of rail below mattress level, zone three at 1.5 inches and zone four at zero inches with ends of the rail below mattress level. RN- B stated she would complete a bed rail assessment, and then call family to review the risks verses benefits of bed rail use.

R15
R15 began receiving services on May 11, 2021, under the Comprehensive Home Care license and began receiving services under the Assisted Living Facility with Dementia Care (ALFDC) license on August 1, 2021. R15 resided in the assisted living part of the building.

R15's service plan dated August 19, 2022, indicated services included dressing, grooming, transferring, and catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 98 R15's comprehensive assessment dated October 19, 2022, indicated R15 had bilateral hospital style bed rails. The assessment identified "Hospital (Enter Length of Side Rail Zone 1,2,3 must not exceed 4.75 inches)", however no measurements were documented within the assessment. Although the zones had not been measured, the assessment indicated the risks and benefits of side rails had been discussed with resident and/or responsible party. R15's unsigned Nursing Tool for Hospital Beds dated October 19, 2022, identified the following: - Zone 1 - 2.75 inches - Zone 2 - 3 inches - Zone 3 - 1.5 inches The assessment and clinical record lacked evidence zone 4 was measured as required. On November 29, 2022, at 9:01 a.m., observed ULP-F complete catheter cares for R15. R15 was lying on a hospital bed with attached bilateral half side rails, in the upright position, on the upper part of the bed. R15 stated she uses them to help with turning and transferring. On November 30, 2022, at 11:00 a.m. RN-B stated she had completed measurements of the side rail. All the hospital side rails were "the same" and therefore the measurements would be the same. She had the measurements on a form in R15's paper chart. RN-B further stated the measurements should have been written on the assessment. RN-B did not recognize the measurements required could be altered by differences in mattresses and those differences in measurements could place a resident with siderails at risk for injury or death.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 99 R9 R9 began receiving services on May 27, 2020, under the Comprehensive home care license. R9's service plan dated February 22, 2022, indicated services included assistance with bathing, dressing, grooming, and medication management. R9 began receiving services under the Assisted Living Facility with Dementia Care (ALFDC) license on August 1, 2021. R9 resided in the assisted living part of the building. R9's comprehensive assessment dated August 25, 2022, identified R9 had a U-shaped grab bar device. Risks and benefits had been discussed with the resident or the representative. The assessment and client record lacked evidence to identify if the device had been installed per manufacturer guidelines, or the licensee had checked for recalls for the device. On November 30, 2022, at 11:00 a.m., R9 was observed to have a consumer side rail device on her bed. The device was U-shaped with a fabric cover over the open area within the rail. The bars continued between the mattress and the box spring and it was also a U-shape. Attached to the device, between the mattress and box spring, was a long strap that connected securely to the opposite side of the bed frame. There was also a small strap that connected the device and the long strap. On November 30, 2022, at 11:20 a.m., registered nurse (RN)-B stated she did not have a copy of the manufacturer directions for the device and she had not checked for recalls for the device. RN-B stated she was unaware of the requirements.	02310		

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02310	Continued From page 100 The licensee's Nursing Tool for Hospital Beds dated July 8, 2022, identified the following: "When the [the licensee] community is aware a home care resident is utilizing side rails (a medical device) on a bed, Nursing will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail." Assessment "When side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. If the side rail is acting as a restraint, appropriate action should be taken. RN will also determine need for PT/OT evaluation to help determine appropriateness of device." Education "The resident and, when appropriate, the resident's representative, shall be informed of the risks and benefits regarding the use of side rails. Education provided will be documented in the resident record. Verify the medical device is safe: "1. Staff from [the licensee] community will determine if the side rail is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below: a. The side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. c. The side rail design is consistent with the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 101 FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4.75". The licensee's Resident Assistive Devices policy dated July 2022, "Resident and/or Responsible Party agrees not to use or apply bed rails or other assisted device of any type without first notifying facility and allowing facility to conduct an assessment to determine the risk: benefit of device use. The facility reserves the right to request further evaluation by physical/occupational therapist and/or a physician. The following information is provided to the resident upon admission and/or prior to installation of the device and specifically bed rail/assist bars: -Resident acknowledges bed rails are most often considered a restraint and may cause serious injury including fractures, asphyxiation, strangulation and death. In the event it is determined by facility staff that the device/rail(s) poses a greater risk for injury than benefit for Tenant's use, Resident agrees to not apply/utilize the device(s). -In the event a bed rail maybe determined to be a benefit to Resident, Resident will be responsible for purchase of the bed rail(s) that is approved by the manufacturer for use with Resident's bed frame as not all bed rails are compatible with all bed types. Resident also acknowledges and agrees that portable bed rail{s) that do not attach to the bed frame are never allowed due to their inherent risk. -Resident agrees to provide facility with a copy of the manufacturer guidelines for any consumer grade device. -Resident also agrees that even if a bed rail is	02310		

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	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 102 initially determined to be a benefit by Facility, if the bed rails are later determined to pose a greater risk for injury than benefit the bed rails will be removed. -Any device applied to a hospital style bed must comply with FDA requirements including measurements as identified in the guideline; https://www.fda.gov/medical-devices/hospital-beds/guide-bed-safety-bed-rails-hospitals-nursing-homes-and-home-health-care-facts." "Facility clinical staff will be responsible for completing the appropriate assessments and reviewing the risk benefits of such devices with residents and responsible parties." "The facility will adhere to the following assessment and monitoring schedule: · PT /OT eval for therapeutic placement of device · Initial Assessment of the Devices-Nursing Assessment/Physical Device Tool · Quarterly Review of Device or with Change of Condition in Nursing Assessment and/or- Physical Device Assessment" "For Consumer Bed Rails- · An assessment was completed; · the bed rails were determined to not act as a restraint; · the portable bed rails were installed and maintained according to the manufacturer's guidelines; · the manufacturer's guidelines are accessible upon request (hint: you may need to search the bed rail for identifying manufacture and model number, and/or do a Google search to download the installation and maintenance instructions); · and the risk vs. benefits were discussed and documented with the resident/responsible party."	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

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02310	Continued From page 103 "For Hospital Style Beds and Devices: · Purpose and intention of the bed rail · Measurements · The resident's bed rail use/need assessment · Risk vs. benefits discussion (individualized to each resident's risks) · The resident's preferences · Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation." "Non-hospital style beds (consumer/regular beds): Licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." "Hospital style beds with rails: · an assessment was completed by nursing; · measurements are completed and documented; · the rails are FDA compliant; · even if bed is provided by hospice and has rails, the assisted living licensee is still responsible to make sure the assist rail is within regulations and Bed Rail guideline & protocol." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), zone 2 (space under the rail, between the rail supports) zone 3 (space between the rail and mattress), should be less than 4 and 3/4 inches. Zone 4 (space under the rail at the ends of the rail, between the rail and mattress) should be less than 2 and 3/8 inches.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

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02310	Continued From page 104 The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(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
02310	Continued From page 105 guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy was removed as confirmed by onsite observation and document review on December 1, 2022; however, non-compliance remains at level three, widespread (I). TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Full
Date: *11/28/22*
Time: 14:56:23
Report: 7962221234

Food and Beverage Establishment Inspection Report

Location:
Sugar Loaf Senior Living
765 Menard Road
Winona, MN55987
Winona County, 85

Establishment Info:
ID #: 0038928
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074521277
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COOLER UNDER SERVING WINDOW; SLICED TURKEY 44DF, SLICED TOMATO 51DF, TOMATO DISCARDED. WAITRESS AREA: GALLON OF MILK ON ICE

Comply By: 11/28/22

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

MEMORY CARE KITCHEN DISH WASHING MACHINE 0PPM, STAFF WILL USE MAIN KITCHEN FOR WASHING DISHES UNTIL CORRECTED

Comply By: 11/28/22

4-700 Sanitizing Equipment and Utensils

4-702.11 ** Priority 1 **

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

FOOD DEBRIS ON SLICER AND LARGE MIXER

Comply By: 11/28/22

5-200A Plumbing: approved materials/design

5-201.11A ** Priority 1 **

MN Rule 4626.1040A Provide a plumbing system that is designed, constructed, installed, and repaired with approved materials, equipment, and devices complying with chapter 4714 and Minnesota Statutes, sections 326B.43 to 326B.49.

THREE COMPARTMENT SINK IS INDIRECTLY DRAINED TO A FLOOR SINK, WORK WITH A LICENSE PLUMBER TO CORRECT, REMOVE UNUSED WAITRESS AREA WATER FILTER AND PLUMBING

Comply By: 12/12/22

5-200B Plumbing: cross connections

5-203.14A ** Priority 1 **

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

WATER SOFTENER DISCHARGE LINE DOES NOT HAVE SUFFICIENT AIR GAP, FACT SHEET SENT WITH REPORT

Comply By: 12/05/22

5-200B Plumbing: cross connections

5-203.14I ** Priority 1 **

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

ALL MOP SINKS HAVE Y-SPLITTERS WITH CONTROL VALVE DOWN STREAM FROM ATMOSPHERIC VACUUM BREAKER BACKFLOW

Comply By: 12/05/22

4-200 Equipment Design and Construction

4-203.11 ** Priority 2 **

MN Rule 4626.0555 Replace food temperature measuring devices that are not accurate to plus or minus 2 degrees F.

INTERIOR THERMOMETER 20DF MEMORY CARE KITCHEN, DISCARDED

Comply By: 11/28/22

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

EYE WASH STATION ON HAND WASH SINK FAUCETS, REMOVE,

COFFEE SHOP USED HAND WASH SINK AS WATER SOURCE FOR COFFEE AND WATER
Comply By: 12/05/22

2-100 Supervision

2-102.12AMN

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

NO STATE OF MINNESOTA CERTIFIED FOOD PROTECTION MANAGER (CFPM) ON SITE, CHEF SHAWN DAVIS SCHEDULED FOR CLASS AND EXAM, LINK TO CFPM APPLICATION SENT WITH REPORT
Comply By: 11/28/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12E

MN Rule 4626.0275E Store food preparation or dispensing utensils that are used with non-TCS foods, such as ice, in a clean, protected location.

SCOOP IN FLOUR
Comply By: 11/28/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WIPING CLOTH HANGING ON HAND WASH SINK AND IN DISH MACHINE AREA
Comply By: 11/30/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

WAITRESS AREA FRUIT ADJACENT TO TOXICS AND HAND WASH SINK, REMOVED
Comply By: 11/28/22

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

CAULK AROUND DIRTY SIDE OF DISH MACHINE PEELING, CAULKING AROUND HOOD FALLING OFF
Comply By: 12/05/22

4-500 Equipment Maintenance and Operation

4-501.113

MN Rule 4626.0800 Maintain the flow pressure of the hot water sanitizing rinse in the warewashing machine within the range specified on the manufacturer's data plate but not less than 5 psi or more than 30 psi.

PRESSURE GAUGE ON DISH MACHINE 38 PSI

Comply By: 12/12/22

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

CAULK AROUND DIRTY SIDE OF DISH MACHINE MOLDY, EQUIPMENT SURFACES, WALK-IN COOLER FAN COVERS DIRTY MOLDY, BROWN STREAK DOWN SIDE OF WALK-IN COOLER

Comply By: 11/30/22

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

INTERIOR OF MICROWAVE DIRTY

Comply By: 11/30/22

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

CLEAN DISHES UNDER HAND WASH SINK DISPOSABLE TOWELS, DRIPPED ON WHEN RETRIEVING DISPOSABLE TOWELS

Comply By: 11/30/22

4-900 Protecting Clean Items

4-903.11B

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying, and covered or inverted.

CLEAN DISHES STACKED WET

Comply By: 11/30/22

4-900 Protecting Clean Items

4-904.11A

MN Rule 4626.0965A Handle, display, and dispense all single-service and single use articles and clean utensils so that contamination of lip-contact and food-contact surfaces is prevented.

COFFEE SHOP: PILE OF PLASTIC FORKS ON SERVING TABLE, DISCARDED

Comply By: 11/28/22

6-300 Physical Facility Numbers and Capacities

6-305.11B

MN Rule 4626.1480B Provide lockers or other suitable facilities for the orderly storage of employees' clothing and other possessions.

PERSONAL ITEMS INTERMINGLED WITH SINGLE USE FOOD CONTAINERS, MAINTENANCE ITEMS, FIRST AID

Comply By: 11/30/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.113B

MN Rule 4626.1575B Store maintenance and cleaning equipment in an orderly manner that facilitates the cleaning of the storage area.

UNABLE TO ACCESS KITCHEN MOP SINK AREA DUE TO DISORDERLY STORAGE

Comply By: 11/30/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.114AB

MN Rule 4626.1580AB Remove all items unnecessary to the operation or maintenance of the establishment and litter from the premises.

REMOVE UNUSED EQUIPMENT

Comply By: 11/30/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

TOP OF DISH MACHINE, FLOOR/WALL/CEILING SURFACES ALL AREAS OF KITCHEN, GREASE PUDDLES AROUND COOK LINE, MOP SINK

Comply By: 11/30/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

MOPS NOT HUNG

Comply By: 11/30/22

Surface and Equipment Sanitizers

Sink and Surface: = 700 ppm at Degrees Fahrenheit
Location: dispenser on three compartment sink
Violation Issued: No

Hot Water: = at 166 Degrees Fahrenheit
Location: max/min thermometer sent through machine
Violation Issued: No

Hot Water: = at 190 Degrees Fahrenheit
Location: Sanitizing rinse, thermometer on machine
Violation Issued: No

Sink and Surface: = 272 ppm at Degrees Fahrenheit
Location: dispenser at scrap sink
Violation Issued: No

Chlorine: = 0ppm at Degrees Fahrenheit
Location: memory care kithchen dish washing machine, staff will use main kitchen for washing dishes until corrected
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 44 Degrees Fahrenheit - Location: sliced ham, interior thermometer
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: sliced turkey
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 51 Degrees Fahrenheit - Location: sliced tomato
Violation Issued: Yes

Process/Item: Out of Refrigeration
Temperature: 40 Degrees Fahrenheit - Location: sliced tomato on grilled cheese, about to go onto grill
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: interior thermometer
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: tuna canned opened today
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 36 Degrees Fahrenheit - Location: precooked turkey opened to be sliced 11/27
Violation Issued: No

Process/Item: Cooling Ambient
Temperature: 43 Degrees Fahrenheit - Location: lettuce salad prepped today
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 33 Degrees Fahrenheit - Location: orange juice memory care kitchen
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 20 Degrees Fahrenheit - Location: interior thermometer #1 memory care kitchen, discarded
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 30 Degrees Fahrenheit - Location: interior thermometer #2 memory care kitchen
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 32 Degrees Fahrenheit - Location: exterior thermometer memory care kitchen
Violation Issued: No

Process/Item: Hot Holding
Temperature: 140 Degrees Fahrenheit - Location: soup waitress area
Violation Issued: No

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

Process/Item: Out of Refrigeration
Temperature: 39 Degrees Fahrenheit - Location: gallon of milk on ice
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	6	2	16

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 7962221234 of 11/28/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Shawn Davis
Chef

Signed:_____
Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
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