Electronically Delivered

July 29, 2022

Administrator
Country View Senior Living
810 8th Street
Walnut Grove, MN 56180

RE: Project Number(s) SL35904015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 29, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

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

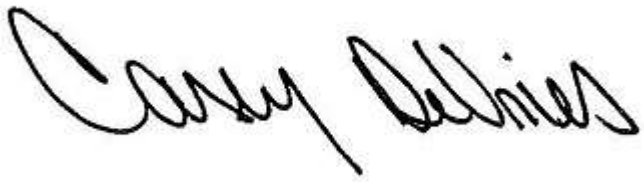
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 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
	35904	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VIEW SENIOR LIVING	810 8TH STREET WALNUT GROVE, MN 56180

(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: SL35904015-0 On June 27, 2022, through June 29, 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 20 residents, 17 of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all of the licensee's 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Licensed assisted living director (LALD)-A had a license effective through October 31, 2022; however, LALD-A's license lacked the licensee listed as the Director of Record with BELTSS. On June 27, 2022, at approximately 12:45 p.m., LALD-A stated she was not aware that she was required to be listed as the Director of Record for this facility and stated she would call BELTSS. The licensee's Assisted Living Director policy, dated December 21, 2021, indicated the licensee was required to have an LALD permitted by	0 110		

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0 110	Continued From page 2 BELTTS; however, lacked direction to list as the Director of Record for the facility. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470		

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0 470	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and post the required staffing plan potentially affecting the licensee's 20 current residents, staff and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a licensee's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee holds an assisted living facility license with a bed capacity of 20 residents; current census was 20 residents. On June 27, 2022, at 1:15 p.m., during the facility tour with licensed assisted living director (LALD)-A, the surveyor observed the entrance of the facility and common areas. The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to: - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On June 27, 2022, at approximately 2:08 p.m., LALD-A verified the daily staffing schedule was not posted and stated the staff schedule never changed because the staffing needs remained the same every day. LALD-A stated the licensee	0 470		

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0 470	Continued From page 4 had developed a staffing plan; however, had not posted the daily staffing schedule, as required. The licensee's Staffing, Direct Care Staffing Plan, & Daily Schedule policy, dated August 1, 2021, indicated the clinical nurse supervisor, or designee, would develop, write, and implement a staffing plan and would provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven days a week, and would develop a 24-hour daily staffing schedule that would be posted at the beginning of each shift in a central location, accessible to staff, residents, volunteers and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
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 5 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all 20 residents residing at the facility. 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 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 June 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	0 510		

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0 510	Continued From page 6 Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of one unlicensed personnel (ULP)-B observed to clean hearing aides for R5, and then providing medications to R2. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 28, 2022, at approximately 10:11 a.m., the surveyor observed ULP-B while preparing to clean R5's hearing aides. ULP-B entered R5's room, donned gloves and removed R5's right hearing aide from his ear. ULP-B used an alcohol prep and a tool to clean the hearing aide, set it on the side table next to R5's recliner, and then removed the left hearing aide. While cleaning the hearing aide, ULP-B's pager that was hooked on the outside of his scrub pants pocket, sounded, and without removing the soiled gloves, ULP-B	0 510		

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0 510	Continued From page 7	0 510		

held the pager in his hands and pushed buttons until the pager cleared. ULP-B continued to clean the hearing aide, and then changed the battery in each hearing aide. ULP-B placed the hearing aides back into R5's ears. ULP-B's pager sounded again, and he held it in his gloved hands to clear the pager. ULP-B gathered the supplies, went into the kitchen area of the apartment, removed the soiled gloves, and threw the garbage and the soiled gloves into the trash. ULP-B told R5 he would be back shortly, and without performing hand hygiene, left the apartment. ULP-B stated the pager had sounded because R2 was ready for her medications. Without performing hand hygiene, ULP-B knocked and entered R2's apartment, greeted R2, reached into his pocket and used a key to unlock the medication drawer in the kitchen. Without performing hand hygiene, ULP-B gathered R2's medication punch cards and verified each medication on his cell phone while he punched each medication into a paper medication cup. ULP-B handed R2 an inhaler, which she used to administer two puffs, and R2 stated the inhaler was now empty. ULP-B handed R2 the medication cup which she brought to her mouth and then drank from a cup of liquid. ULP-B returned the medication cards to the medication drawer and locked the drawer. Without performing hand hygiene, ULP-B left R2's room, carrying the empty inhaler, and walked upstairs to dispose of the inhaler. ULP-B came back down the stairs, and stated he needed to go to another resident's room to administer medications. On the way to the next room, ULP-B used the hand sanitizer dispenser in the hallway.

On June 28, 2022, at approximately 10:38 a.m., ULP-B confirmed he did not perform hand hygiene after removing the soiled gloves and

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0 510	Continued From page 8	0 510		

exiting R5's room, or before entering R2's room and setting up her medications. ULP-B verified that hand hygiene should be performed when completing tasks, removing gloves, when leaving a resident's room, and when entering the next resident's room to complete a task.

On June 28, 2022, at approximately 10:47 a.m., licensed assisted living director (LALD)-A, whom is also the licensee's registered nurse, indicated hand hygiene should always be performed when removing gloves and when going from one resident room to another. LALD-A also indicated staff should not touch pager or other items with soiled gloves.

The licensee's Standard (Universal) Precautions for Infection Control policy, dated August 1, 2021, directed, staff will wash hands before putting on gloves, immediately after gloves are removed, and between all patient contacts. Also included, gloves should be removed promptly after use, and before touching non-contaminated items, environmental surfaces, self, or other residents, and hands washed after removing gloves.

The licensee's Hand Hygiene policy, dated August 1, 2022, directed hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Also included, "Use of gloves does not replace hand washing." Hands should be washed or decontaminated before and after direct contact with a resident, after contact with environmental surfaces or equipment in the immediate vicinity of the resident, and after removing gloves.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7)

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0 510	Continued From page 9 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, interview and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all of the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 640		

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0 640	Continued From page 10 The findings include: On June 27, 2022, at 1:15 p.m., during the facility tour with licensed assisted living director (LALD)-A, the surveyor observed the facility entry and common areas and noted the licensee failed to post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. On June 27, 2022, at approximately 1:50 p.m., LALD-A confirmed the required content was not posted. The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy, dated December 21, 2021, indicated the licensee would post information for reporting suspected crime and maltreatment and would support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment, by posting information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VIEW SENIOR LIVING	810 8TH STREET WALNUT GROVE, MN 56180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 11 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, 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	0 680		

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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
0 680	Continued From page 12 portion or all of the residents). The findings include: During the initial tour with licensed assisted living director (LALD)-A on June 27, 2022, at approximately 1:15 p.m., the surveyor observed the facility's layout included the main entrance on the ground level which included a large common area, dining room, resident rooms, and an upper level with common areas, staff area, office space and resident rooms. There were hand drawn emergency exit diagrams posted on each level in the common areas; however, there was no evidence of the emergency disaster plan posted prominently, as required. On June 27, 2022, at approximately 2:12 p.m., LALD-A confirmed the emergency disaster plan was not posted prominently and stated the emergency preparedness manual was typically kept in the staff area in the upper level; however, stated the manual had recently been kept in her office while she worked on it. The licensee's policy, Emergency and Disaster Preparedness, dated December 28, 2021, indicated the licensee would post the emergency disaster plan prominently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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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
0 800	Continued From page 13 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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. This had the potential 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: On a facility tour on June 27, 2022, at approximately 2:50 p.m. with Licensed Assisted Living Director (LALD)-A and Vice President of Assisted Living Operations (VPALO)-E it was observed in the south furnace room on first floor that there was a large hole cut in the fire rated wall assembly between this room and the egress stairwell to run a new air conditioning line that was not repaired which compromised the fire integrity of the wall and egress stairwell.	0 800		

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0 800	Continued From page 14 It was also observed in the laundry room on the first floor that there appeared to be mold or similar substance on the water damaged ceiling tiles that resulted from a water leak. It was also observed in the main mechanical room on first floor around the sump pump that there appeared to be mold or similar substance on the wet and water damaged sheetrock wall. It was also observed in the corridor on the first floor outside the main bathroom that there appeared to be mold or similar substance on the water damaged ceiling tiles that resulted from a water leak. An interview with LALD-A verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	0 810		

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0 810	Continued From page 15 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to provide annual training to residents capable of self-evacuation on the fire safety and evacuation plan for the facility. This had the potential 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:	0 810		

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0 810	Continued From page 16 A record review and interview were conducted on June 27, 2022, at approximately 2:50 p.m. with Licensed Assisted Living Director (LALD)-A and Vice President of Assisted Living Operations (VPALO)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. During interview, VPALO-E indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire and only provided training annually per Emergency Preparedness Manual. During interview, VPALO-E verified this deficient finding. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, LALD-A and VPALO-E stated that the licensee does provide education to the resident on fire safety and evacuation at admission and at tenant meetings but could not provide documentation to support these occurrences. A policy on resident training for fire safety and evacuation but requested one was not able to be	0 810		

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0 810	Continued From page 17 provided. Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. During interview, LALD-A indicated that the licensee had not conducted evacuation drills every other month as required and had no documentation to provide. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01700 SS=D	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 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	01700		

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01700	Continued From page 18	01700		

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 record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment with the required content for one of two residents (R2) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:

During the entrance conference on June 27, 2022, at approximately 11:45 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the licensee's residents.

R2
R2's record lacked evidence the RN had conducted a medication assessment to include:
- identification and review of all medication.

R2's Assisted Living Contract, effective August 9, 2021, was signed by R2 on that day.

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01700	Continued From page 19 R2's Service Plan, dated August 13, 2021, indicated R2 received services which included assistance with bathing, medication assistance, blood glucose monitoring, oxygen maintenance, housekeeping and laundry. The included medication assessment and medication management plan lacked the above required content. R2's prescriber orders printed August 9, 2021, included two blood pressure medications, two medications used to prevent heart attacks, one injectable insulin, one medication to decrease fluid retention, one oral medication to treat diabetes, one medication to decrease cholesterol, one antidepressant, one supplement and two inhalers. On June 28, 2022, at approximately 3:12 p.m., LALD-A, whom is also the licensee's registered nurse, confirmed the assessment lacked the above required content. The licensee's Initial and On-Going Nursing Assessment of Residents policy, dated August 1, 2021, indicated the RN would complete a comprehensive assessment and would review medications including over-the-counter medications, prescription medications, and supplements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 20 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed and administered according to manufacturer's instructions for one of one resident (R2) during administration of an inhaler, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes, chronic obstructive pulmonary disease (COPD) (chronic inflammatory lung disease that causes obstructed	01760		

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01760	Continued From page 21 airflow from the lungs), hypertension (high blood pressure) and depression. R2's Service Plan, dated August 13, 2021, indicated R2 received services which included assistance with bathing, medication assistance, blood glucose monitoring, oxygen maintenance, housekeeping and laundry. R2's prescriber orders, signed August 27, 2021, included Symbicort 160-4.5 mcg (micrograms), inhale two puffs by inhalation twice daily, and directed, "RINSE MOUTH AFTER INHALATION." R2's Med (medication) Admin (administration) Summary, dated June 2022, directed "Symbicort (Daily) Tenant to self administer TWO puffs twice a day via inhalation. RINSE MOUTH AFTER INHALATION." On June 28, 2022, at approximately 10:22 a.m., the surveyor observed unlicensed personnel (ULP)-B conduct a medication pass for R2 which included administration of oral medications and the Symbicort inhaler. ULP-B gathered R2's medication punch cards from the locked kitchen drawer and verified each medication on his cell phone while he punched each medication into a paper medication cup. ULP-B handed the Symbicort inhaler to R2, which she brought to her mouth and took two slow inhalations. R2 took a sip of liquid from a cup and swallowed. ULP-B did not instruct the resident to rinse her mouth out after the administration of the inhaler. ULP-B then handed the medication cup to R2 which she brought to her mouth, and then took a drink of liquid from the cup and swallowed. ULP-B asked R2 if she needed anything and then left the room. On June 28, 2022, at approximately 10:38 a.m.,	01760		

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01760	Continued From page 22 ULP-B confirmed he had not instructed R2 to rinse her mouth out following administration of the Symbicort inhaler and stated he had never done that before and was unaware it was necessary. On June 28, 2022, at approximately 10:47 a.m., licensed assisted living director (LALD)-A, whom is also the licensee's registered nurse, stated staff are trained to instruct the resident to rinse their mouth after using the inhaler and stated it was included in R2's inhaler administration directions on the medication administration record, as well as in the policy. LALD-A confirmed ULP-B should have reminded R2 to rinse her mouth after administration of her inhaler. The manufacturer's instructions for use of the Symbicort inhaler, last updated November 2020, directed to rinse mouth with water after breathing in the medications, to spit out the water and not to swallow the water. The licensee's Inhaler policy, dated December 21, 2021, directed to provide the resident the opportunity to rinse out mouth. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

DEPARTMENT OF HEALTH

Type: Full
Date: *06/28/22*
Time: 10:45:17
Report: 1033221055

Food and Beverage Establishment Inspection Report

Location:
Country View Senior Living
810 8th Street
Walnut Grove, MN56180
Redwood County, 64

Establishment Info:
ID #: 0038099
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5078592133
ID #:

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

The following orders were issued during this inspection.

4-600 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.

Hood system has visible grease and soil build up.

Comply By: 06/28/22

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: Sweet and Sour Sauce-Refrigerator
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Diced Tomatoes-Regrigerator
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Freezers
Violation Issued: No

Type: Full
Date: *06/28/22*
Time: 10:45:17
Report: 1033221055
Country View Senior Living

Food and Beverage Establishment Inspection Report

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

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

I acknowledge receipt of the inspection report number 1033221055 of 06/28/22.

Certified Food Protection Manager: Kimberly K Rolling

Certification Number: FM52206 Expires: 03/05/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Kimberly K Rolling

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us