Electronically Delivered

June 5, 2023

Licensee
The Lodge Of Taylors Falls, LLC
1051 Mulberry Street
Taylors Falls, MN 55084

RE: Project Number(s) SL31891015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 17, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

the specific statute(s).

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

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

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

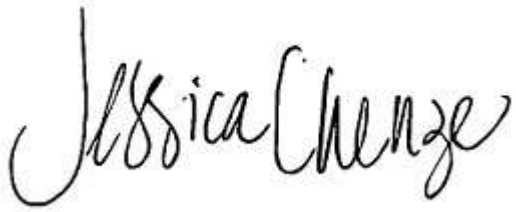
Please address your cover letter for reconsideration requests to:

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796
PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31891	A. BUILDING: _____ B. WING _____	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE OF TAYLORS FALLS LLC	1051 MULBERRY STREET TAYLORS FALLS, MN 55084

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31891015 On May 15, 2023, 2023, through May 17, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 14 residents receiving services under the 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 16, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	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 2 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 ensure infection control standards were followed for one of one employee (unlicensed personnel (ULP)-B) during wound care for R3. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On May 16, 2023, at 6:47 a.m., the surveyor observed ULP-B provide wound care services to R3's lower left extremity. R3 was seated in a chair in her apartment. ULP-B gathered supplies from a cabinet in R3's kitchen area. ULP-B applied hand sanitizer and donned a pair of gloves. ULP-B removed two Band-Aids from R3's lower leg and sprayed Simply Saline (saline solution for wound treatment) onto R3's lower leg, cleaning the area. ULP-B then patted the area dry. With the same gloved hand ULP-B reached for a container of Gold Bond lotion. ULP-B applied the lotion to R3's lower right leg. With the same gloved hand ULP-B applied one Band-Aid to R3's lower left leg. The surveyor did not observe ULP-B perform hand hygiene after removing Band-Aids, performing wound care to R3's left	0 510		

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0 510	Continued From page 3 leg, or prior to applying lotion to R3's right leg. On May 16, 2023, at 7:05 a.m., ULP-B stated she had wondered why only one of R3's legs had wounds, adding "other staff do it that way, one glove." ULP-B stated a single Band-Aid was applied to R3's left lower leg because only one area was currently bleeding. On May 16, 2023, at 1:37 p.m., clinical nurse supervisor (CNS)-C stated ULP-B's gloves should have been changed after wound care and hand hygiene should have been performed prior to lotion application. The licensee's Personal Protective Equipment (PPE) including Putting on/Taking off, All Service Lines policy dated October 21, 2022, noted gloves should be worn anytime working with body fluids, changing dressing on wounds and when performing diagnostic procedures. Disposable gloves should be replaced as soon as practical when contaminated or as soon as feasible. When performing care services, remove gloves after contact with resident, patient, and children and/or the surrounding environment using proper technique to prevent hand contamination. Change gloves during resident, patient and childcare if the hands move from a contaminated body site to a clean body site. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management	0 580		

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0 580	Continued From page 4 appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living 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) 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 May 15, 2023, at 12:07 p.m., during the entrance conference, the surveyor asked licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C about the licensee's quality management activities. CNS-C stated they	0 580		

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0 580	Continued From page 5 "chat" formally every three weeks. CNS-C added she would reach out to find out if there was any documentation. On May 15, 2023, at 1:35 p.m., LALD-A stated she spoke with supervisor last week about setting up the process for quality management. On May 16, 2023, at approximately 11:30 a.m., CNS-C and LALD-B said they did not currently have a quality management program. The licensee's State-Specific Senior Living Information-Minnesota policy dated October 13, 2022, noted the facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluation the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to resident. Documentation about quality management activity must be available for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
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:	0 650		

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0 650	Continued From page 6 (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; (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for one of one employee, (unlicensed personnel (ULP)-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, 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: ULP-B was hired on October 22, 2021, to provide	0 650		

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0 650	Continued From page 7 direct care services to residents of the facility. On May 16, 2023, at 6:47 a.m., the surveyor observed ULP-B administer R3's morning medication. ULP-B's employee record did not include documentation of training and competency for medication management for unplanned times away. On May 16, 2023, at 11:02 a.m., clinical nurse supervisor (CNS)-C said she verbally taught and deemed ULP-B and all other ULPs competent of the following: -preparing medications for unplanned times away. On May 16, 2023, at 3:00 p.m., CNS-C said education of medications for unplanned time away was completed with the medication training for all ULPs. CNS-C stated there was no documentation of the training or competency for preparing medications for unplanned times away for any of the ULPs. The licensee's State-Specific Senior Living Information-Minnesota policy dated October 13, 2022, noted employee records would include records of orientating, required annual training, infection control training, and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 680	Continued From page 8	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to comply with the frequency of inspections and load test requirements for the facility's emergency power system (permanent generator) as part of the facility's emergency disaster and preparedness plan as required under Minnesota Rules, Part 4659.0100. This had the potential to affect the current resident receiving services under the assisted living	0 680		

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0 680	Continued From page 9 license, as well as any staff and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 16, 2023, at approximately 1:15 p.m. survey staff requested the documentation related to inspection, maintenance, and load test records of the emergency power generator as part of the facility's shelter-in-place emergency disaster and preparedness plan for review. The director of maintenance (DM)-D searched for the documentation but was not successful in locating the documentation. The DM-D stated that he believes the generator runs an automatic weekly quick run but is unsure of the details. On May 16, 2023, at approximately 1:30 p.m., a documentation review and interview with the LALD-A and the DM-D revealed the licensee failed to provide the minimum frequency of weekly inspection and monthly load test requirements for the emergency power generator as outlined under NFPA 110, (as referenced under the Code of Federal Regulations, title 42, section 483.73) to ensure proper performance of the generator. On May 16, 2023, at approximately 1:40 p.m., the LALD-A confirmed the findings during the exit interview. Survey staff agreed to receive	0 680		

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0 680	Continued From page 10 additional records by the end of the day to retrieve any missing generator load tests and inspection records for further review. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 690 SS=E	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the resident or the resident's representative for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 690		

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0 690	Continued From page 11 R1 R1's Service Agreement, Part 1-Agreement dated September 15, 2022, was not authenticated by R1 or R1's representative. R1's Service Agreement, Part II-Services dated September 15, 2022, was not authenticated by R1 or R1's representative. R2 R2's Senior Living Occupancy Agreement dated October 1, 2022, was not authenticated by R2 or R2's representative. On May 16, 2023, at 11:00 a.m., licensed assisted living director (LALD)-B stated R1 and R2 both had items which were not signed by the resident or resident's representative. in their records. LALD-A added, "the person before me had a habit of not getting things signed." The licensee's Medical Record Resident-Assisted Living policy dated February 6, 2023, noted the assisted living community maintained an individual resident medical record that included medical, clinical and psychosocial information for every resident according to generally accepted professional standards and practices. Records would be accurate, accessible, and organized to facilitate information complication and retrieval. State and federal requirements would be met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	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 12 (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 interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff. 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 May 16, 2023, approximately from 10:50 a.m. to 12:45 p.m., survey staff toured the facility with the director of maintenance (DM)-D. During the tour, survey staff observed the following: 1. The two sets of the 20-minute fire-rated doors (smoke barrier) doors on magnetic holders between the dining/office areas and the resident room corridor failed to positively latch when closed preventing the fire-rated doors to protect	0 800		

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	31891	A. BUILDING: _____ B. WING _____	05/17/2023

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0 800	Continued From page 13 and maintaining the smoke-tight integrity of the corridor. 2. The laundry room door was wedged in the open position. The DM-D verified the finding and stated that it should be discussed with the licensed assisted living director (LALD)-A. 3. The reduced pressure zone backflow preventers (RPZ) serving the lawn irrigation system located in the sprinkler riser room (next to the kitchen) were not tagged with the last date it was tested. Survey staff explained to the DM-D that RPZ devices must be tested annually by an approved testing company to prevent cross-connection and ensure the proper performance of RPZ devices to protect the building water supply system. The above findings were visually verified by the DM-D accompanying the tour. On May 16, 2023, at approximately 1:40 p.m., during the exit interview, the LALD-A acknowledge the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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;	0 810		

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0 810	Continued From page 14 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the required training on the fire safety and evacuation plan and the minimum frequency of employee evacuation drills. This has the potential to directly affect the safety of all residents receiving services, 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	0 810		

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0 810	Continued From page 15 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 May 16, 2023, at approximately 12:45 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-A. At approximately 1:15 p.m., document review and interview with the LALD-A and the director of maintenance (DM)-D indicated the following: 1. Documentation review indicated the licensee did not provide annual training to residents who can assist in their evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation. The documentation was requested but no record was provided or available for review. 2. Documentation review indcated the licensee lacked the required minimum employee training specifically on the fire safety and evacuation plan twice a year after new hire orientation on fire safety and evacuation. The LALD-A stated that records were not available but she will ensure the required fire safety and evacuation training will be completed moving forward. 3. Drill record documentation review showed an insufficient number of employee fire evacuation drills performed to date. Fire drill records provided for the review were dated July 29, 2022 (4:30 p.m.), and a tabletop fire drill, dated August 1, 2022 (12:00 a.m.). The fire drill record also lacked evacuation information as the documentation had not included any evacuation	0 810		

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0 810	Continued From page 16 notes and/or details. Survey staff explained to the LALD-A and the DM-D that the minimum frequency of evacuation drills is twice per year per shift with at least one evacuation every other month, totaling six evacuation drills per year that must be carried out to meet the requirements. On May 16, 2023, at approximately 1:45 p.m., during the exit interview, the LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
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 and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060		

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01060	Continued From page 17 (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01060		

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01060	Continued From page 18	01060		

problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R3's diagnoses included major depression, hypertension, and bilateral lower leg edema (swelling).

R3's service plan dated January 1, 2022, indicated services received included medications and treatments as per physician orders.

R3's medication administration record/treatment administration record (MAR/TAR) indicated the resident received services which included monitoring weight, medication administration, wound care, and assist with tubi-grip stockings.

R3's record contained a note dated January 11, 2023, at 4:45 p.m., "(Resident) was admitted to BMC (hospital) for small bowel obstruction. They anticipate several night stay."

R3's record contained a note dated January 30, 2023, at 3:30 p.m., "(Resident) returned from BMC today and is largely at her baseline..."

R3's record lacked a written notice that contained, at a minimum:
- the name and contact information for the location to which the resident has been relocated and any new service provider;
- contact information for the OOLTC;
- 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;
- a statement that, if the facility refuses to provide

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01060	Continued From page 19	01060		

housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.

In addition, R3's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days.

On May 16, 2023, at 2:45 pm., clinical nurse supervisor (CNS)-C stated the OOLTC was not notified regarding R3's leave. CNS-C said she had heard about a form, adding she had not completed the form for any resident's leaves from the facility.

The licensee's Resident Termination and Discharge Planning-AL (assisted living), Minnesota policy dated August 24, 2022, noted facility may emergently remove a resident from the facility due to urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff, Written notice requirements included:
- reason for the relocation;
- name and contact information for the location to which the resident has been relocated and any new service provider;
- contact information for Ombudsman for LTC;
- approximate date or range of dates for resident's expected return (if known) or statement that return date is not known; and
- statement that, if termination notice was given, resident had a right to appeal and contact information for the appeal.
Notice must be delivered as soon as practicable to:
-resident, legal representative, and designated representative;

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01060	Continued From page 20 -resident's case manger for wavered residents; and -Office of Ombudsman for LTC if resident has been relocated and not returned to facility within four (4) days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a	01370		

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01370	Continued From page 21 licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of two employees, (unlicensed personnel (ULP)-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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on October 22, 2021, to provide direct care services to residents of the facility. On May 15, 2023, at approximately 11:45 a.m., during the entrance conference, clinical nursing supervisor (CNS)-C stated the facility offered modified diets, mechanical/texture.	01370		

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01370	Continued From page 22 On May 16, 2023, at 6:47 a.m., the surveyor observed ULP-B administer R3's morning medication and provide wound care. ULP-B's employee record did not include documentation of training for the following: -documentation requirements for all services provided; and -preparation of modified diets as ordered by a licensed health professional. On May 16, 2023, at 1:52 p.m., nursing clinical consultant (NCC)-E stated ULP-B's employee record did not include the above required training and competency evaluations. NCC-E added she was not aware the facility offered modified diets. The licensee's Required Training for All Employees, Minnesota-Assisted Living policy dated December 13, 2022, noted training and competency evaluations for all unlicensed personnel must include: -documentation requirements for all services provided; and -preparation of modified diets as ordered by a licensed health professional. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting	01380		

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01380	Continued From page 23 resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of two employees, (unlicensed personnel (ULP)-B) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on October 22, 2021, to provide direct care services to residents of the facility. On May 16, 2023, at 6:47 a.m., the surveyor observed ULP-B administer R3's morning medication, provide wound care, and apply	01380		

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01380	Continued From page 24 stockings. ULP-B's employee record did not include documentation of training and competency evaluations for the following topics: - range of motion and positioning. On May 16, 2023, at 1:52 p.m., nursing clinical consultant (NCC)-E stated ULP-B's employee record did not include the above required training and competency evaluations. The licensee's Required Training for All Employees, Minnesota-Assisted Living policy dated December 13, 2022, noted training and competency evaluation for all unlicensed personnel must include: -Range of motioning and positioning. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional	01440		

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01440	Continued From page 25 and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two employees, (unlicensed personnel (ULP)-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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on October 22, 2021, to provide direct care services to residents of the facility. On May 16, 2023, at 6:47 a.m., the surveyor observed ULP-B administer R3's morning medication, provide wound care, and apply	01440		

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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
01440	Continued From page 26 stockings. ULP-B's employee record lacked documentation of a registered nurse (RN) supervising ULP-C performing a delegated task within 30 days of beginning work with the licensee. On May 16, 2023, at 11:00 a.m., licensed assisted living director (LALD)-A stated ULP-B's 30-day supervision of performing a delegated task had not been completed as required. LALD-A added that was before her time at the site. On May 16, 2023, at approximately 3:15 p.m., nursing clinical consultant (NCC)-E said ULP-B's record did not contain a 30-day supervision of a delegated task as required. The licensee's State-Specific Senior Living Information-Minnesota policy dated October 13, 2022, noted the RN must directly supervise staff within 30 calendar days after the date on which the individual began working for the facility and first performed the delegated tasks for residents and thereafter as needed based on performance. In addition, documenting of supervision activities must be maintained in personnel records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter;	01470		

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01470	Continued From page 27 (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss	01470		

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01470	Continued From page 28 and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two employees, (unlicensed personnel (ULP)-B)'s employee record contained orientation to assisted living facility licensing to include all the required topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on October 22, 2021, to provide direct care services to residents of the facility. On May 16, 2023, at 6:47 a.m., the surveyor observed ULP-B administer R3's morning medication, provide wound care, and apply	01470		

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01470	Continued From page 29 stockings. ULP-B's employee record lacked evidence of completing the following assisted living orientation before providing assisted living services to the licensee's residents: - policies and procedures related to the provision of assisted living services by the individual staff person; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On May 16, 2023, at 12:29 p.m., licensed applied living director (LALD)-A stated ULP-B's employee record did not contain documentation the above orientation was completed as required. LALD-A said she was not working at the facility at the time ULP-B was hired. The licensee's Required Training for All Employees, Minnesota-Assisted Living policy dated December 13, 2022, noted the orientation would contain: -introduction and review of Society policies and procedures related to provision of services; and -a review of the types of assisted living services the employee would be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the	01530		

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01530	Continued From page 30 following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees, (unlicensed personnel (ULP)-B) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01530		

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01530	Continued From page 31	01530		

limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

ULP-B was hired on October 22, 2021, to provide direct care services to residents of the facility.

On May 16, 2023, at 6:47 a.m., the surveyor observed ULP-B administer R3's morning medication, provide wound care, and apply stockings.

ULP-B's employee record did not indicate a total of eight hours of the required dementia training was completed within 160 hours of the employee's start date.
ULP-B record included Person-Centered Care and Culture Change dated November 10, 2021.

On May 16, 2023 at 3:30 p.m., nursing clinical consultant (NCC)-E said ULP-B's employee record did not include the above required training. NCC-E stated dementia training was required, adding "missed one" (staff).

The licensee's Required Training for All Employees, Minnesota-Assisted Living policy dated December 13, 2022, noted training in Dementia Care required of all direct care staff in assisted living facilities:
Eight hours of dementia training that included:
-an explanation of Alzheimer's disease and related disorders;
-assistance with activities of daily living;
-problem solving with challenging behaviors;
-communication skills; and
-person-centered planning and service delivery.
In addition, direct care workers in Assisted Living

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01530	Continued From page 32 must have completed this training within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01620		

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01620	Continued From page 33 review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment on day 14 for two of three residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 began receiving assisted living services on October 19, 2022. R2's diagnoses included hypertension (HTN), and chronic back pain. R2's service plan dated April 13, 2023, indicated services received included medications and treatments as per physician orders. R2's care plan, entry dated April 13, 2023, noted resident required assistance with setting up and managing a pill box system. RN to set up medications monthly. On May 16, 2023, at approximately 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-B check in on R2. R2's record included a pre-admission assessment dated October 19, 2022, an	01620		

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01620	Continued From page 34 admission assessment effective October 19, 2022, and a change of condition assessment effective April 13, 2023, and authenticated April 18, 2023. R2's resident's record did not include a 14 day assessment. On May 16, 2023, at approximately 1:15 p.m., nursing clinical consultant (NCC)-E stated a reassessment for R2 on or before day 14 was not completed as required. R5 R5 began receiving assisted living services on June 28, 2022. R5's diagnoses included diabetes, HTN, and history of embolism (blood clot). R5's service plan dated May 10, 2023, indicated services received included medications and treatments as per physician orders. On May 16, 2023, at 9:40 a.m., the surveyor observed ULP-B take R5's blood pressure. R5's record included a nurse's note dated June 28, 2022, "pre-admission assessment completed previously," an admission assessment dated June 28, 2022, authenticated July 1, 2022, and a change of condition assessment dated November 22, 2022. R5's resident's record did not include a 14 day assessment. On May 17, 2023, at 8:45 a.m., CNS-C stated R5's record did not include a 14 day assessment. CNS-C said R5 had lived there, moved away and	01620		

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01620	Continued From page 35 returned to the facility. In addition, CNS-C stated she thought by reviewing the admission assessment, and completing it within in 14 days was sufficient. The licensee's State-Specific Senior Living Information-Minnesota policy dated October 13, 2022, noted an assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	01650		

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01650	Continued From page 36 (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R2, R3). This had the potential to affect all residents who received services at 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: R2 R2 began receiving assisted living services on October 19, 2022.	01650		

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01650	Continued From page 37 R2's diagnoses included hypertension (HTN), and chronic back pain. R2's service plan dated April 13, 2023, indicated services received included medications and treatments as per physician orders. R2's care plan, entry dated April 13, 2023, noted resident required assistance with setting up and managing a pill box system. RN to set up medications monthly. On May 16, 2023, at approximately 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-B check in on R2. R2's service plan dated September 14, 2022, did not include: -the method of monitoring staff providing services. R3 R3 began receiving assisted living services on December 15, 2017. R3's diagnoses included major depression, hypertension, and bilateral lower leg edema (swelling). R3's service plan dated January 1, 2022, indicated services received included medications and treatments as per physician orders. R3's medication administration record/treatment administration record (MAR/TAR) indicated the resident received services which included monitoring weight, medication administration, wound care, and assist with tubi-grip stockings.	01650		

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01650	Continued From page 38 On May 16, 2023, at 6:47 a.m., the surveyor observed ULP-B administer R3's morning medication, provide wound care, and apply compression stockings. R3's service plan dated September 14, 2022, did not include: -the method of monitoring staff providing services. On May 16, 2023, at approximately 1:00 p.m., nursing clinical consultant (NCC)-E stated R2 and R3's service plans did not include a method of monitoring staff providing services. NCC-E said this was the first time she was made aware of their (facilities) service plans missing required content. The licensee's Resident Service Plan-Assisted Living policy dated October 3, 2022, noted the Service Plan must be printed and then signed and dated by the resident and the ALC (assisted living community) manager or licensed nurse according to state regulation. In addition, refer to state-specific regulations regarding service plans. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=F	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	01760		

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01760	Continued From page 39 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 documentation as to why a medication was not given and failed to include documentation to include the effectiveness for as needed (PRN) medication administration for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3's diagnoses included major depression, hypertension, and bilateral lower leg edema (swelling). R3's service plan dated January 1, 2022, indicated the resident received services which included medication administration.	01760		

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01760	Continued From page 40 R3's provider's orders dated January 30, 2023, included: -Maalox 200-200-20 milligram (mg)/5 milliliter (ml) (stomach upset/heartburn/gas) 2 tablespoons (T) at bedtime; -zinc oxide (Desitin/skin irritation) apply every night to affected area; -Nystatin 100,000 unit/gram ointment, (yeast) apply to clean dry skin between buttocks daily at bedtime; -Nystatin 100,000 unit/gram powder, to abdominal and groin folds for fungal rash four times a day as needed; and -tramadol 50 mg (pain) every 6 hours as needed (treat moderate to moderately severe pain). On May 16, 2023, at 6:47 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R3's morning medication and provide wound care. MEDICATION ADMINISTERED AS ORDERED R3's medication administration record (MAR) dated May 1, 2023, through May 16, 2023, included: -Maalox 200-200-20 mg/5 ml suspension, take 2 T to equal 30 ml by mouth daily at bedtime. 15 of 15 opportunities Maalox was circled (indication the medication was not given as prescribed-refused, not available). 15 of 15 opportunities R3's record lacked documentation of why the medication was not administered as ordered. -Zinc Oxide 40 % (Desitin) cream apply to red area between buttocks daily. 15 of 15 opportunities Zinc Oxide was circled. 13 of 15 opportunities R3's record lacked documentation of why the medication was not administered as ordered. -Nystatin 100,000 units/gram ointment apply thin layer to clean dry skin between buttocks daily at	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31891	A. BUILDING: _____ B. WING _____	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE OF TAYLORS FALLS LLC	1051 MULBERRY STREET TAYLORS FALLS, MN 55084

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01760	Continued From page 41	01760		

bedtime. 15 of 15 opportunities Nystatin was circled.
-Nystatin 100,000 units/gram powder apply two times/day to clean, dry skin in abdominal, groin, and peri area for red yeast rash. 26 of 30 opportunities Nystatin powder was circled, and one opportunity lacked documentation.

R3's record included documentation 11 times "Nystatin" of why the medication was not administered as ordered. Two (2) of 11 times documentation stated Nystatin cream and powder. 32 times documentation did not indicate if Nystatin cream or powder was not administered as ordered.

PRN MEDICATION
R3's MAR dated May 1, 2023, through May 16, 2023, included:
-tramadol 50 mg take 1 tablet by mouth every 6 hours PRN for pain. 23 of 47 opportunities R3's record lacked documentation of result/effectiveness.

On May 16, 2023, at 2:00 p.m., nursing clinical consultant (NCC)-E stated documentation should be completed for all medications as to why they were not given as ordered. In addition, PRN medication administration required follow up documentation.

On May 16, 2023, at 2:45 p.m., NCC-E and nursing operations consultant (NOC)-F stated there was an issue with PRN documentation "as a whole", records missing follow up/effectiveness documentation.

The licensee's Medication Administration-Assisted Living policy dated October 3, 2022, noted omitted medications

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	31891	A. BUILDING: _____ B. WING _____	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE OF TAYLORS FALLS LLC	1051 MULBERRY STREET TAYLORS FALLS, MN 55084

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01760	Continued From page 42 should be documented on the MAR. The omission is documented by circling the initials of the person responsible for medication administration for that resident. The reason for the omission is documented on the reverse side of the MAR. In addition, follow-up documenting would include asking the resident to comment on whether they felt the PRN medication was effective or not and documenting the resident's response. If the resident was unable to comment, the medication aide should document that the response to the medication was "unknown." The licensee's Medication Administration and Supporting Processes policy dated January 28, 2022, noted before shift change, all staff should check MARs to determine if all medications administered were properly documented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R2).	01770		

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01770	Continued From page 43 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: R2's diagnoses included hypertension (HTN), and chronic back pain. R2's service plan dated April 13, 2023, indicated services received included medications and treatments as per physician orders. R2's care plan, entry dated April 13, 2023, noted resident requires assistance with setting up and managing a pill box system. RN to set up medications monthly. On May 16, 2023, at 8:50 a.m., the surveyor observed three medication dosage boxes on a side table in R2's living room. R2's provider's orders dated May 15, 2023, included: -furosemide (diuretic) 20 milligrams (mg), 2 tablets in morning, 1 in pm (afternoon); -levothyroxine (hypothyroidism) 200 micrograms (mcg), 1 tablet daily (best if taken on empty stomach); -losartan (high blood pressure) 50 mg, take 1 tablet daily; -magnesium oxide 400 mg, daily; -potassium chloride milliequivalents (mEq), 2	01770		

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01770	Continued From page 44	01770		

tablets by mouth once daily with a meal;
-pramipexole (restless leg syndrome) 0.125 mg, take 2 tablets by mouth every day at 3 pm and take 3 tablets at bedtime; and
-sertraline (depression) 50 mg, take 1 tablet by mouth once daily.

R2's record contained nurse's notes:
May 8, 2023, at 3:25 p.m.: Medication set up, resident requested RN (registered nurse) set up medication only in AM (morning) pill box. She (resident) provided RN with many OTC (over the counter) and RX (prescription) medications. RN reconciled these with provider orders and set up medications as ordered for May 9, through May 12, 2023.

May 12, 2023, at 4:45 p.m.: Medication set up: RN set up AM medications from May 13, through May 15, 2023, due to MD (medical doctor) appointment on May 15, 2023, and possibility of new orders.

May 15, 2023, at 7:00 p.m.: Medication Set up: RN reviewed signed medication list received today and set up AM medication through May 19, 2023. Also faxed letter with OTC/supplement asking for orders.

On May 16, 2023, at 12:21 p.m., clinical nurse supervisor (CNS)-C stated when setting up medication for residents she goes off of the medical providers order list, adding she makes a note in the resident's record.

The licensee's Pillbox Setup and Management-Assisted Living policy dated August 15, 2022, noted the nurse would manage the pillbox in the following manner:
-obtain the labeled medication container from the

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	31891	A. BUILDING: _____ B. WING _____	05/17/2023

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01770	Continued From page 45 storage area or the resident; -transfer the medication from the original container into a pillbox, labeled with the resident's name, according to the day and time increments as prescribed by the healthcare provider; -according to the healthcare provider's orders, fill the medication pillbox for a recommended one-week timeframe; -return the original medication container to the storage area or resident; and -document the date and time the pillbox was filled in the resident's record using interdisciplinary progress notes/ if in the electronic medical record (EMR), the medication administration record (MAR), treatment administration record (TAR) or in the nursing orders module. In addition, the licensed nurses would follow state regulation for any specific documentation components required for the pillbox setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record	02320		

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02320	Continued From page 46 review, the licensee failed to ensure the steps of delegated task process were followed for one of one employee, (unlicensed personnel (ULP)-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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on October 22, 2021, to provide direct care services to residents of the facility. On May 16, 2023, at 6:47 a.m., the surveyor observed ULP-B remove R3's calendar (documenting weight on Monday), and R3's medication and treatment record. ULP-B initialed lotion to dry skin, tubi-grip application, and wound care. ULP-B removed R3's medication and prepared them for administration. ULP-B administered R3's morning medication to R3 and documented R3's medication administration. ULP-B completed wound care, applied lotion, and stockings to R3's lower legs. Directly following the above observation ULP-B stated she signed out applying lotion, applying tubi-grips and wound care prior to completing them. ULP-B said, "I know I am going to be doing them (task), that is my way." ULP-B's record included Skill Competency/Wound Care dated October 31, 2021, included:	02320		

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02320	Continued From page 47 -know if/how the wound is to be cleaned and gather those supplies; -know what type of ointment, if any, is to be applied: -know what type of dressing specified and bring to client; -bring 2 pair of clean gloves-one for removing the soiled dressing and another for applying clean dressing; -explain to your client what you would be doing; -arrange your supplies next to where client is sitting or lying; -wash your hands and apply gloves; -gently remove the tape around dressing; gently removed the soiled dressing being careful no to pull and removed wound tissue; -observe the wound; -gather soiled dressing in gloved left hand. Remove left hand glove by pinching the top of the glove and pulling off and gather it into gloved right hand. Take ungloved left fingers and slide under right glove, pulling glove off with other glove and dressing secured inside; everything ending up within the 2nd glove. Dispose of soiled materials according to company policy; -wash your hands and apply a clean pair of gloves; -clean the wound according to Care Plan. Pat dry with gauze pad; -apply ointment, if specified; -apply clean dressing/bandage and secure; remove gloves, wash hands; -return supplies to appropriate storage; and -document. ULP-B's record also included: -compression stocking education completed November 1, 2021; -personal cares education completed November 8, 2021; and	02320		

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02320	Continued From page 48 -infection prevention I and II completed October 27, 2021 and August 31, 2022 respectively. On May 16, 2023, at 1:40 p.m., clinical nurse supervisor (CNS)-C stated tasks (applying lotion, applying tubi-grips, and wound care) should be documented on after completion, not prior to it. The licensee's Treatment and Therapy Management Services-Minnesota policy dated May 11, 2023, noted when administration of a treatment or therapy is delegated to unlicensed personnel, the assisted living provider must ensure that the registered nurse or authorized licensed health professional has; -instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *05/16/23*
Time: 11:00:00
Report: 1025231119

Food and Beverage Establishment Inspection Report

Location:
The Lodge Of Taylors Falls Llc
1051 Mulberry Street
Taylors Falls, MN55084
Chisago County, 13

Establishment Info:
ID #: 0039070
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6512400140
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

Provide a means of testing the internal temperature of the dish machine (e.g. temp strips or min/max thermometer)

Comply By: 05/19/23

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Flat top griddle does not meet the above standard ("For Household Use Only"). Replace the unit with one that meets standards (see order for cleaning range flat top)

Comply By: 05/16/23

4-600 Cleaning Equipment and Utensils

4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.

Maintain the surface of the range flat top to be free of grease and other accumulation; provide a smooth cooking surface.

Comply By: 05/19/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 300 at Degrees Fahrenheit
Location: 3 compartment sink
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: 2 door upright cooler
Violation Issued: No

Process/Item: Ambient
Temperature: 33 Degrees Fahrenheit - Location: Neighborhood refrigerator
Violation Issued: No

Process/Item: Milk
Temperature: 39 Degrees Fahrenheit - Location: Neighborhood refrigerator
Violation Issued: No

Process/Item: Chicken, reported precooke
Temperature: 135 Degrees Fahrenheit - Location: Heating for service 135-180 F
Violation Issued: No

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

Sanitizer use – reported quat ammonia used on food contact surfaces in the kitchen; peroxide and quat ammonia used in dining area. For non-food contact surfaces, soap and water is permissible to maintain surfaces cleaned and sanitized (to protect finish over wood so wood/absorbent surface does not become exposed); use a sanitizer on tables that won't damage the surface.

Griddle – the portable griddle does not meet MN 4626.0506 for cooking equipment for the facility based on the menu (For Household Use Only). The existing griddle on the range unit needs cleaning/resurfacing (currently being used for hot holding). Clean the griddle so it can be used as a flat top cooking surface instead of the portable household griddle.

Location does not have a convenient (safe) means of hot holding food for routine service; recommend a tabletop steam unit or other hot holding equipment which meets MN 4626.0506. Having dedicated equipment that is easy to use and intended specifically for institutional service would also be easier to use for less experienced staff.

Location has a dish machine and no 3 compartment sink. Ensure there is a means of chemical sanitizing in case of an emergency (e.g. a bus tub system dedicated to W/R/S of utensils, using quat ammonia as a sanitizer).

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025231119 of 05/16/23.

Certified Food Protection Manager: Mary (Peterson)

Certification Number: FM33738 Expires: 03/05/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Mary

Signed: _____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231119

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 05/16/23
Time In 11:00:00
Time Out

The Lodge Of Taylors Falls Llc	Address: 1051 Mulberry Street	City/State: Taylors Falls, MN	Zip Code: 55084	Telephone: 6512400140
License/Permit #: 0039070	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O — Proper cooking time & temperature		
19	IN OUT N/A N/O — Proper reheating procedures for hot holding		
20	IN OUT N/A N/O — Proper cooling time & temperature		
21	IN OUT N/A N/O — Proper hot holding temperatures		
22	IN OUT N/A — Proper cold holding temperatures		
23	IN OUT N/A N/O — Proper date marking & disposition		
24	IN OUT N/A N/O — Time as a public health control: procedures & records		
Consumer Advisory			
25	IN OUT N/A — Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26	IN OUT N/A — Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A — Food additives: approved & properly used		
28	IN OUT — Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29	IN OUT N/A — Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30		IN OUT N/A — Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32		IN OUT N/A — Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34		IN OUT N/A N/O — Plant food properly cooked for hot holding		
35		IN OUT N/A N/O — Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49	X	Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 05/16/23

Inspector (Signature) Cory Kline