DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

May 10, 2023

Licensee
The Wellstead of Rogers
20600 South Diamond Lake Road
Rogers, MN 55374

RE: Initial License Number 408932
Health Facility Identification Number (HFID) 30762
Project Number(s) SL30762015

Dear Licensee:

On April 11, 2023, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the initial survey completed December 27, 2022. The follow-up survey found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective April 11, 2023.**

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 27, 2022, initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on December 27, 2022, found not corrected at the time of the April 11, 2023, follow-up survey and subject to a penalty assessment are as follows:

0650-Employee Records-144g.42 Subd. 8
1470-Content Of Required Orientation-144g.63 Subd. 2
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f)
1880-Storage Of Medications-144g.71 Subd. 19 - $500.00
1890-Prescription Drugs-144g.71 Subd. 20
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3
2110-Policies-144g.82 Subd. 3 - $500.00

The details of the violations noted at the time of this follow-up survey completed on April 11, 2023, (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on April 11, 2023, we identified the following violation(s):

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
0970-Waivers Of Liability Prohibited-144g.50 Subd. 5

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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 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).

IMPOSITION OF FINES:

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.

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

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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and/or state form with your organization's Governing Body.

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30762	A. BUILDING: _____ B. WING _____	R 04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSTEAD OF ROGERS	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL30762015-1 On April 10, 2023, through April 11, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 27, 2023. At the time of the survey, there were 39 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	{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: No further action required.	{0 480}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (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	{0 650}		

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{0 650}	Continued From page 2 review, the licensee failed to ensure training documentation was maintained for one of four unlicensed personnel ((ULP)-C) 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) 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-C was hired on February 2, 2018, under the licensee's former comprehensive license and started providing assisted living services on August 1, 2021. On April 11, 2023, between 11:16 a.m. and 11:44 a.m., the evaluator observed ULP-C provide toileting and transfer assistance to two residents. ULP-C's record lacked documentation of completed training for understanding appropriate boundaries between staff, residents, and the resident's family. On April 10, 2023, at 1:25 p.m., licensed assisted living director (LALD)-T provided the evaluator with an undated untitled document that contained a monthly training schedule. LALD-T stated the training to cover the required topic listed above was to be completed in the month of April. LALD-T stated they have been reminding employees to complete the training however, not all employees had completed the topic.	{0 650}		

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{0 650}	Continued From page 3 On April 11, 2023, at 11:46 a.m., the evaluator inquired if ULP-C received training in the topic listed above. ULP-C stated they received the training; however, they could not remember how or when they received the training. On April 11, 2023, at 1:17 p.m., clinical nurse supervisor (CNS)-S stated all employees should complete Relias (training software program) training prior to working on the floor. In addition, CNS-S stated they believed ULP-C had completed all training however, they may have misplaced the documentation. The licensee's Orientation Training, Evaluation and Supervision of Unlicensed Personnel policy dated February 10, 2023, indicated ULPs who were not registered nursing assistants would receive additional training including appropriate boundaries between staff, residents, and resident's families. The licensee's Personnel Records policy dated February 1, 2023, indicated personnel records would be kept up to date, well organized and confidential and will comply with the assisted living law and other relevant laws. In addition, the personnel record would include required training for unlicensed personnel and would be retained for at least three years after an employee ceased to be employed. No further information provided.	{0 650}		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 4 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for four of five employees (registered nurse (RN)-U, unlicensed personnel (ULP)-E, ULP-H, ULP-V). 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: The licensee's TB facility risk assessment worksheet dated May 11, 2022, indicated the licensee's setting was a low risk for TB.	0 660		

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0 660	Continued From page 5 RN-U RN-U was hired March 2, 2023, to provide assisted living services. RN-U's employee record included a positive QuantiFERON-TB gold (TB blood test) dated September 20, 2021, and chest x-ray dated September 27, 2021. RN-U's employee record lacked documentation of a TB history and symptom screening completed at hire. ULP-E ULP-E was hired on April 26, 2021, under the comprehensive license and started providing assisted living services August1, 2021. ULP-E's employee record lacked documentation of a TB history and symptom screen, a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test (TB blood test). ULP-H ULP-H was hired on October 13, 2020, under the comprehensive license and started providing assisted living services August1, 2021. ULP-H's employee record included a chest x-ray dated October 6, 2020. ULP-H's employee record lacked documentation of a TB history and symptom screen, a positive two-step TST or IGRA test or documentation of refusal of both the two-step TST and IGRA completed prior to the chest x-ray. ULP-V ULP-V was hired October 20, 2022, to provide assisted living services.	0 660		

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0 660	Continued From page 6 ULP-V's employee record included a negative QuantiFERON-TB gold plus dated October 26, 2022. ULP-V's employee record lacked documentation of a TB history and symptom screening completed at hire. On April 11, 2023, at 11:30 a.m., licensed assisted living director (LALD)-T stated previous management had employee record documentation all over, nothing was easily found, and he was unable to locate the symptom screen or proof of a positive two-step TST or IGRA test for ULP-E. On April 11, 2023, at 1:26 p.m., clinical nurse supervisor (CNS)-S stated upon hire employees were to complete a screening form for active signs of TB and would complete a two-step TST or a chest x-ray. In addition, CNS-S stated they became aware of the missing documentation for TB in the employee records during survey and have started to make corrections by printing off baseline TB screening tools and auditing employee records. The licensee's Infection Prevention and Control Program policy dated February 9, 2023, indicated upon hire all staff were screened for active signs of TB using the baseline TB screening tool provided by the Minnesota Department of Health (MDH) or a similar tool with all required information. In addition, all employees are tested for TB with either a two-step Mantoux or an IGRA laboratory blood test which results would be maintained in the personnel record. No further information was provided.	0 660		

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0 660	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{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 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation	{0 810}		

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{0 810}	Continued From page 8 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: No further action required.	{0 810}		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the	0 970		

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0 970	Continued From page 9 licensee's liability for health, safety, or personal property of a resident for five of five residents (R1, R4, R7, R22, R23). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at 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: R1 R1 admitted to the licensee January 27, 2015, under the comprehensive license, and started receiving assisted living services August 1, 2021. R1's Assisted Living Contract was sent to family for signature via mail and email on April 6, 2023. R4 R4 admitted to the licensee November 3, 2020, under the comprehensive license, and started receiving assisted living services August 1, 2021. R4's Assisted Living Contract was sent to family for signature via mail and email on April 6, 2023. R7 R7 admitted to the licensee October 26, 2022, for assisted living services. R7's Assisted Living Contract was sent to family for signature via mail and email on April 6, 2023. R22 R22 was admitted to the licensee March 18,	0 970		

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0 970	Continued From page 10 2020, under the comprehensive license, and started receiving assisted living services August 1, 2021. R22's Assisted Living Contract was signed on April 5, 2023. R23 R23 was admitted to the licensee September 20, 2020, under the comprehensive license, and started receiving assisted living services August 1, 2021. R23's Assisted Living Contract was signed on April 6, 2023. R1, R4, R7, R22, and R23's Residency Agreement included language which indicated waivers of liability for the following: Page 11: Section E: Insurance "We will not be responsible for any damage, loss or injury to your property ... caused by theft, fire, water or other casualty." On April 11, 2023, at 1:31 p.m., licensed assisted living director (LALD)-T stated he was not aware the contract contained language waiving the licensee's liability for health, safety, or personal property of a resident. In addition, LALD-T stated the licensee had two lawyers review the contract prior to sending the contract to residents and resident families for signatures. No further information was provided.	0 970		
{01470} SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics:	{01470}		

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{01470}	Continued From page 11 (1) an overview of this chapter; (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:	{01470}		

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{01470}	Continued From page 12 (1) an explanation of age-related hearing loss 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 interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing services for one of five employees (registered nurse (RN)-U). 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: RN-U was hired March 2, 2023, to provide direct care services to residents at the assisted living facility. RN-U's employee records lacked the following	{01470}		

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{01470}	Continued From page 13	{01470}		

required orientation content:
- overview of assisted living statutes;
- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;
- handling of emergencies and use of emergency services;
- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
- consumer advocacy services; and
- principles of person-centered planning.

On April 10, 2023, at 1:45 p.m., licensed assisted living director (LALD)-T stated RN-U may not have finished all training courses assigned to them in Relias (online education system) because they had been employed for a little over a month.

On April 11, 2023, at 1:13 p.m., clinical nurse supervisor (CNS)-S stated RN-U received training on assessments and was "deemed competent" to complete assessments independently. In addition, RN-U had completed multiple assessments independently since hire. CNS-S stated they were not sure if RN-U completed all topics prior to independently completing resident assessments. In addition, CNS-S stated they were the only RN able to complete resident assessments until RN-U started, and they immediately trained RN-U on assessments so the licensee could stay compliant with timeliness of resident assessments.

The licensee's Orientation policy dated February 9, 2023, indicated all assisted living employees would complete an orientation to assisted living facility licensing requirement and regulations

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{01470}	Continued From page 14 before providing services to residents. No further information provided.	{01470}		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the	{01650}		

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{01650}	Continued From page 15 licensee failed to ensure the service plan was revised to include all services being provided for one of five residents (R23). 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: R23's service plan dated March 24, 2023, indicated R23 received the following services: housekeeping, bathing, toileting, grooming, dressing, medication administration, and every 90-day assessments. R23's medication administration record (MAR) dated April 2023, indicated R23 received services to include blood glucose testing twice daily in the morning and evening. The blood glucose results between the dates April 1, 2023, and April 11, 2023, ranged between 88 milligrams per deciliter (mg/dL) and 491 mg/dL. R23's provider orders dated June 23, 2022, indicated test blood glucose daily, alternate between morning and evening related type 2 diabetes mellitus. R23's Senior Living Resident Evaluation (90-day assessment) dated April 3, 2023, indicated blood glucose monitoring by staff. On April 11, 2023, at 2:25 p.m., clinical nurse	{01650}		

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{01650}	Continued From page 16 supervisor (CNS)-S stated the licensee could not explain how the blood glucose monitoring was missed from the service plan, as all assessments were recently completed by the registered nurse (RN). CNS-S also stated the licensee will update the service plan to reflect the actual services R23 received. The licensee's Resident Service Plan policy dated February 9, 2023, indicated "all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN". No further information provided.	{01650}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access for five of five residents (R1, R25, R26, R27, R28). 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	{01880}		

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{01880}	Continued From page 17 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: R1 On April 11, 2023, at 8:50 a.m., the evaluator observed A and D ointment tube on R1's bathroom counter without a prescription label on tube. R1's apartment door was fully opened and there were seven residents in the common area in the Chickadee Memory unit. R1's service plan dated April 1, 2023, indicated R1 received medication management services including secure storage. R25 On April 11, 2023, at 10:54 a.m., the evaluator observed one cough suppressant topical analgesic 1.76 ounce (oz) tub on R25's nightstand and one Sarna Camphor 0.5 % menthol 0.5 % 7.5 oz bottle with a prescription label in R25's bathroom. R25's apartment door was fully opened and there were five residents in the common area and one resident ambulating in the hallway in the Blue Bird secured unit. R25's service plan dated March 10, 2023, indicated R25 received medication management services including secure storage. R26 On April 11, 2023, at 9:00 a.m., the evaluator observed bacitracin ointment without a prescription label and barrier cream on R26's nightstand. R26's apartment door was fully opened and there were seven residents in the common area in the Chickadee secured unit.	{01880}		

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{01880}	Continued From page 18 R26's service plan dated March 15, 2023, indicated R26 received medication management services including secure storage. R27 On April 11, 2023, at 9:10 a.m., the evaluator observed one unlabeled moisture barrier cream, one unlabeled saline mist bottle, one unlabeled 2 percent (%) cortisone cream, and one unlabeled tube of Bengay on R27's bathroom counter. R27's apartment door was fully opened and there were seven residents in the common area in the Chickadee secured unit. R27's service plan dated March 17, 2023, indicated R27 received medication management services including secure storage. R28 On April 11, 2023, at 9:03 a.m., the evaluator observed one ketoconazole shampoo bottle with a prescription label on R28's bathroom counter. R28's apartment door was fully opened and there were seven residents in the common area in the Chickadee secured unit. R28's service plan dated March 17, 2023, indicated R28 received medication management services including secure storage. On April 11, 2023, at 11:05 a.m., clinical nurse supervisor (CNS)-S verified they did not have an order or assessment indicating R1, R26, R27, and R28's medication could be left in their apartments. On April 11, 2023, at 1:20 p.m., clinical nurse supervisor (CNS)-S stated medications should be stored in the locked medication cart. In addition, CNS-S stated barrier creams and pastes were	{01880}		

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{01880}	Continued From page 19 allowed to be unsecured if a provider order was obtained however, CNS-S verified they did not have an order or assessment indicating R25's medication could be left in the apartment The licensee's Medication Management Guidelines policy dated February 9, 2023, indicated medication supervision or assistance and medication administration would be performed in accordance with state laws and regulation and infection prevention and control policies and guidelines. No further information was provided.	{01880}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were properly disposed from the medication cart for one of two residents (R24). 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	{01890}		

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{01890}	Continued From page 20 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 11, 2023, at 8:35 a.m., the evaluator observed the Chickadee memory care neighborhood medication cart contained the following expired medications for R24: - trazodone hydrochloric acid (hcl) 50 milligram (mg) tablets take one tablet by mouth as needed expired February 7, 2023; and - quetiapine 25 mg tablet give one half tablet by mouth as needed expired March 2023. On April 11, 2023, at 8:42 a.m., unlicensed personnel (ULP)-V stated the medication cart is audited weekly for expired medications and the audit was completed by the registered nurse (RN). ULP-V also stated when the medication passers (ULPs assigned to pass medication) discovered expired medication, they would give it to the RN. On April11, 2023, at 11:15 a.m., clinical nurse supervisor (CNS)-S stated the medication carts were audited weekly. CNS-S also stated the RN missed the expired medication and will instruct them to be more vigilant with auditing. The licensee's Disposal of Unused or Discontinued Prescription Drugs policy dated February 9, 2023, indicated medications must be disposed of consistent with Minnesota requirements, except for controlled substances. Whenever possible, the RN will work with the local pharmacy to see if it can provide a container for non-controlled drugs needing destruction and collect and destroy these drugs on a regular basis". The policy lacked verbiage to include	{01890}		

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{01890}	Continued From page 21 medication cart audit and disposal of expired medication. No further information was provided.	{01890}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	{01940}		

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{01940}	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R23). 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: R23's service plan dated March 24, 2023, indicated R23 received the following services: housekeeping, bathing, toileting, grooming, dressing, medication administration, and every 90-day assessments. R23's medication administration record (MAR) dated April 2023, indicated R23 received services to include blood glucose testing twice daily in the morning and evening. The blood glucose results between the dates April 1, 2023, and April 11, 2023, ranged between 88 milligrams per deciliter (mg/dL) and 491 mg/dL. R23's provider orders dated June 23, 2022, indicated test blood glucose daily, alternate between morning and evening related type 2 diabetes mellitus. R23's Senior Living Resident Evaluation (90-day	{01940}		

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{01940}	Continued From page 23 assessment) dated April 3, 2023, indicated blood glucose monitoring by staff. R23's resident record lacked a treatment or therapy management plan to include all required content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received. On April 11, 2023, at 12:25 p.m., clinical nurse supervisor (CNS)-S stated the licensee had not implemented a treatment or therapy management plan for R23. In addition, CNS-S stated the licensee's charting and documenting system lacked the treatment or therapy management plan content to prompt the registered nurse (RN) when documenting to complete it. No further information provided.	{01940}		
{02110} SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided	{02110}		

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{02110}	Continued From page 24 based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and designated representatives at the time of move in for five of five residents (R1, R4, R7, R22, R23).	{02110}		

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{02110}	Continued From page 25	{02110}		

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:

R1 admitted to the licensee January 27, 2015, under the comprehensive license, and started receiving assisted living services August 1, 2021.

R4 admitted to the licensee November 3, 2020, under the comprehensive license, and started receiving assisted living services August 1, 2021.

R7 admitted to the licensee October 26, 2022, for assisted living services.

R22 was admitted to the licensee March 18, 2020, under the comprehensive license, and started receiving assisted living services August 1, 2021.

R23 was admitted to the licensee September 20, 2020, under the comprehensive license, and started receiving assisted living services August 1, 2021.

R1, R4, R7, R22 and R23's resident records lacked evidence the residents or their representatives received the written policies and procedures at the time of move-in to the facility.

On April 11, 2023, at 1:34 p.m., licensed assisted living director (LALD)-T provided the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30762	A. BUILDING: _____ B. WING _____	R 04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSTEAD OF ROGERS	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

(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
{02110}	Continued From page 26 evaluator with the required ten dementia policies and stated the licensee kept the dementia policies at the front desk and online for all residents who may request them. LALD-T further stated licensee did not keep documentation of who had received the policies, because the licensee was not aware of this requirement. The licensee's undated Dementia License Policies policy included the ten required dementia policies and indicated the policies would be provided to the residents and/or resident's designated representative at the time of move-in. No further information was provided.	{02110}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

January 20, 2023

Licensee
The Wellstead Of Rogers
20600 South Diamond Lake Road
Rogers, MN 55374

RE: Conditional License Number 408932
Health Facility Identification Number (HFID) 30762
Project Number(s) SL30762015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a licensing evaluation on December 27, 2022, for the purpose of assessing compliance with state licensing statutes. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90-day conditional license due to expire on **April 20, 2023**.

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

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

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

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $3,000.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00
St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - $3,000.00

The total amount you are assessed is $12,500.00. 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:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

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

CONDITIONAL LICENSE ISSUED:
MDH will issue The Wellstead Of Rogers a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if The Wellstead Of Rogers is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** The Wellstead Of Rogers will not admit any new residents

under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. The Wellstead Of Rogers must provide the Department:

i. A list of the names and birthdates of any individuals The Wellstead Of Rogers is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents by location including:
    1. Name and birthdate of each resident
    2. Physical location of each resident
    3. Current payment source for services
    4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
    5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. Consultant: The Wellstead Of Rogers will contract with an RN to provide consultation concerning all resident(s) to whom The Wellstead Of Rogers provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from The Wellstead Of Rogers. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with The Wellstead Of Rogers and MDH must review the RN's credentials and approve the selection. The Wellstead Of Rogers is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to The Wellstead Of Rogers in an effort to help The Wellstead Of Rogers align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. The Wellstead Of Rogers will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies The Wellstead Of Rogers and the RN consultant about a change. Each report will be electronically submitted to Jess Schoenecker, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at Jess.Schoenecker@state.mn.us. Jess Schoenecker can be reached at 651-201-3789 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of The Wellstead Of Rogers to correct the violations cited during the evaluation as well as to determine the overall practice of The Wellstead Of Rogers in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. Corrective Action Plan: The Wellstead Of Rogers will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if The Wellstead Of Rogers is in substantial compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license

period. If MDH determines The Wellstead Of Rogers is in substantial compliance on the follow up evaluation, MDH will remove the conditions from The Wellstead Of Rogers's assisted living facility license, and The Wellstead Of Rogers will correct violations identified during the evaluation to come into substantial compliance. If MDH determines The Wellstead Of Rogers is not in substantial compliance, MDH may take additional enforcement action against The Wellstead Of Rogers, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing 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
Health.HRD.Appeals@state.mn.us

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

If you have any questions, please contact Jess Schoenecker directly at: 651-201-3789.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30762	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSTEAD OF ROGERS	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

(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: SL30762015-0 On December 19, 2022, through December 22, 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 79 active residents; 70 receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on December 19, 2022, issued for SL30762015-0, tag identification 0110. This immediate order was issued at a level two, widespread violation, however was later increased to a level three, widespread violation, following the issuance of three additional immediate orders for correction on December 22, 2022. Immediate correction orders were identified on December 22, 2022, issued for SL30762015-0, tag identification 1620, 1750, and 1950.	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.	

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0 000	Continued From page 1 On December 23, 2022, the immediacy of correction order 0110 was removed, however non-compliance remained at a scope and level of I. On December 27, 2022, the immediacy of correction orders 1620, 1750, and 1950 was removed, however non-compliance remained at a scope and level of G, I, and G, respectively.	0 000		
0 100 SS=F	144G.10 Subdivision 1 License required 144G.10 Subdivision 1. License required. (a)(1)?Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter.? (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).? (b)?The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.? (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).? (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each	0 100		

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0 100	Continued From page 2 building located on the campus in which assisted living services are provided.? (e) Upon approving an application for an assisted living facility license, the commissioner may:? (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or? (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain accurate licensure when they included four secured dementia care units in their license capacity number despite those units being in a different building with a different street address. 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). 144G.10 ASSISTED LIVING FACILITY LICENSE. Subdivision 1. License required. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated	0 100		

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0 100	Continued From page 3 by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). The facility was licensed as an Assisted Living with Dementia Care (ALFDC) facility and had a license effective, August 1, 2022, for a capacity of 164 residents. During a facility tour with registered nurse (RN)-A on December 19, 2022, at 10:40 a.m., RN-A stated four of the licensee's twelve secured dementia care units were located across the parking lot in a separate building, with a separate entrance and different street address from the licensee. RN-A stated those units were under the street address of 20500, the licensee's sister facility, which operated under a different license type, an assisted living facility (ALF). RN-A stated although the four units were included in the licensee's ALFDC capacity, they were not currently in use and had no residents housed there. On December 20, 2022, at 11:03 a.m., RN-A stated the corporate office was aware of the secured units in the ALF building, but RN-A was not sure of the reasoning. On December 20, 2022, at 11:10 a.m., regional director (RD)-G stated the licensee was aware of the secured units under the ALF building address, but licensee has not had any residents in these units since April 2019. RD-G also stated they would contact the licensee's corporate office to find more information about the four locked units within the 20500 building. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required 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 employment of an assisted living director (LALD) licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all 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 of the residents). The findings include: On December 19, 2022, at 9:56 a.m., registered nurse (RN)-A stated the licensee did not have a LALD for the facility, the previous LALD left December 8, 2022, and the new LALD would start January 5, 2023. The licensee's Alternate Executive Director Designation policy, dated April 1, 2019, indicated an individual is designated as responsible for planning, organizing, and directing the day-to-day	0 110	This immediate order was issued at a level two, widespread violation, however was later increased to a level three, widespread violation, following the issuance of three additional immediate orders for correction on December 22, 2022. On December 23, 2022, the immediacy of correction order 0110 was removed.	

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0 110	Continued From page 5 operations of the community during the executive director's absence from the community or a vacancy in the position of executive director. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy was removed by evaluation supervisor review on December 23, 2022, however noncompliance remained at a scope and severity of I. This immediate order was issued at a level two, widespread violation, however, was later increased to a level three, widespread violation, following the issuance of three additional immediate orders for correction on December 22, 2022. TIME PERIOD FOR CORRECTION: Seven (7) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 250	Continued From page 6 misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements	0 250		

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	30762	A. BUILDING: _____ B. WING _____	12/27/2022

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0 250	Continued From page 7 of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 19, 2022, at approximately 10:03 a.m., registered nurse (RN)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page five and six of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess	0 250		

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0 250	Continued From page 8 [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police,	0 250		

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0 250	Continued From page 9 local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by owner (O)-O on May 25, 2022. The licensee had an assisted living license issued	0 250		

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0 250	Continued From page 10 on August 1, 2022, with an expiration date of September 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - reminders for treatments; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. On December 22, 2022, at 3:45 p.m., RN-A confirmed the licensee provided Assisted Living with Dementia Care but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0100, 0110, 0430, 0450, 0480, 0485, 0490, 0510, 0630, 0700, 0730, 0800, 0810, 0900, 1060, 1290, 1370, 1380, 1420, 1440, 1470, 1500, 1540, 1620, 1640, 1650, 1700, 1710, 1730, 1750, 1760, 1880, 1890, 1940, 1950, 1960, 2090, 2110, 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		

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0 430	Continued From page 11	0 430		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services with the required content for four of five residents (R1, R3, R4, R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at 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).	0 430		

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0 430	Continued From page 12 The findings include: R1 R1 admitted to licensee January 27, 2015, and started receiving assisted living services August 1, 2021. R1's service plan dated May 27, 2022, indicated R1 received assistance with medication administration, bathing assistance, dressing, grooming, housekeeping, laundry, ambulation, dining assistance, transfer, and toileting assistance. R3 R3 admitted to licensee for assisted living services on March 7, 2022. R3's service plan signed on August 28, 2022, indicated R3 received assistance with housekeeping, laundry, transfers, bathing, grooming, dressing, meals, activities, medication administration, behavior management, and toileting. R3's unsigned service plan printed December 21, 2022, indicated R3 received oxygen management. R4 R4 admitted to licensee November 3, 2020, and started receiving assisted living services August 1, 2021. R4's service plan dated November 20, 2022, indicated R4 received assistance with medication administration, elopement behaviors, fall risk, bathing assistance, dressing, grooming, housekeeping, laundry, ambulation, dining/eating assistance, transfer, and toileting assistance.	0 430		

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0 430	Continued From page 13 R5 R5 was admitted to licensee May 19, 2021, and started receiving assisted living services August 1, 2021. R5's service plan dated May 19, 2021, indicated R5 received assistance with medication administration, behavior management, fall risk, bathing assistance, dressing, grooming, housekeeping, laundry, transfers, and toileting assistance. R1, R3, R4, and R5's records lacked a uniform disclosure of assisted living services and amenities (UDALSA) checklist to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On December 19, 2022, at 3:40 p.m., registered nurse (RN)-A stated licensee did not provide R1, R3, R4, R5 or any other resident with a written checklist listing all services provided under the licensee's assisted living with dementia care license, and the services not provided under the license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		

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0 450	Continued From page 14	0 450		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights (BOR) for assisted living residents to five of five residents (R1, R2, R3, R4, R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at 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 the residents). The findings include: R1 admitted to licensee January 27, 2015, and started receiving assisted living services August 1, 2021. R2 admitted to licensee August 1, 2019, and	0 450		

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0 450	Continued From page 15 started receiving assisted living services August 1, 2021. R3 admitted to licensee for assisted living services on March 7, 2022. R4 admitted to licensee November 3, 2020, and started receiving assisted living services August 1, 2021. R5 admitted to licensee May 19, 2021, and started receiving assisted living services August 1, 2021. R1, R2, R3, R4, and R5's record lacked evidence the residents had received the assisted living BOR. On December 19, 2022, at 3:40 p.m., registered nurse (RN)-A stated licensee did not provide R1, R2, R3, R4, R5 or any other of the residents with the assisted living BOR. The licensee's Resident Rights policy dated April 1, 2019, did not address the requirements of the current assisted living licensure. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
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:	0 480		

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0 480	Continued From page 16 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 21, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) 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: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to offer at least three nutritious meals daily, according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables and failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 485		

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0 485	Continued From page 18 a minimal impact on the resident and does not affect health or safety) 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 the residents). The findings include: AVAILABLE MENU On December 19, 2022, at 10:30 a.m., during entrance conference, registered nurse (RN)-A stated a dietitian developed the menus. In addition, RN-A stated the licensee provided three meals per day, served per Minnesota (MN) Food Code. On December 19, 2022, at 12:38 p.m., the surveyor was provided two meal menus titled Lunch Diamondcrest and Dinner Diamondcrest dated December 18, 2022, through December 24, 2022, and December 25, 2022, through December 31, 2022, from the front desk. The meal menu lacked a breakfast menu to be provided to the residents. MENU REQUIREMENTS On December 19, 2022, at 12:38 p.m., the surveyor observed a lunch menu dated December 18, 2022, to December 24, 2022, which contained the following: - Sunday, December 18 - beef pot pie, sweet corn, dinner roll. Dessert - chef's choice; - Monday, December 19 - chicken chow mein, egg roll, jasmine rice, oriental vegetables. Dessert - fresh baked cookies; - Tuesday, December 20 - spaghetti and meatballs, stewed tomatoes, breadstick. Dessert - chef's choice; - Wednesday, December 21 - steak strips & rice,	0 485		

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0 485	Continued From page 19 gravy, capri vegetables, dinner roll. Dessert - cherry crisp; - Thursday, December 22 - chicken cordon blue, scalloped potatoes cabbage, dinner roll. Dessert - glazed donuts; - Friday, December 23 - fish and chips, broccoli slaw, dinner roll. Dessert - strawberry ice cream; and - Saturday, December 24 - chicken alfredo, buttered linguini, green beans, garlic bread. Dessert - chocolate chip muffin. In addition, the surveyor observed a dinner menu dated December 18, 2022, to December 24, 2022, which contained the following: - Sunday, December 18 - pepperoni pizza, tator tots/ketchup, chef's blend vegetable. Dessert - chef's choice; - Monday, December 19 - meatloaf, mashed potatoes/gravy, mixed vegetables, dinner roll. Dessert - apple pie; - Tuesday, December 20 - kielbasa, sauerkraut, country vegetables, roasted red potatoes. Dessert - ice cream novelty; - Wednesday, December 21 - chicken club sandwich, steamed broccoli, rice pilaf, dinner roll. Dessert - peach cobbler; - Thursday, December 22 - California burger, lettuce, tomato, pickle, French fries/ketchup. Dessert - cookie bar; - Friday, December 23 - fried shrimp/cocktail sauce, onion rings/ketchup, coleslaw, dinner roll. Dessert - Jell-o poke cake; and - Saturday, December 24 - Salisbury steak, green beans, mashed potatoes/gravy, corn bread. Dessert - fresh baked Danish. The menus lacked at least three nutritious meals daily according to the recommended dietary allowances in the USDA guidelines.	0 485		

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0 485	Continued From page 20 On December 20, 2022, from approximately 7:45 a.m. through 8:10 a.m., the surveyor observed no fruit offered or served to residents for breakfast. On December 21, 2022, from approximately 9:45 a.m. through 11:30 a.m., the surveyor observed no fruit offered or served to residents for breakfast. On December 21, 2022, from approximately 11:50 a.m. through 12:30 p.m., the surveyor observed no fruit offered or served to residents for lunch. On December 19, 2022, at 1:16 p.m., dietary (D)-D stated the licensee did not provide a breakfast menu to the residents. D-D then stated they attempted to implement a breakfast menu since August 2022 however, the licensee did not allow a breakfast menu to be created. D-D stated they "free style it" for breakfast and make what was available. In addition, D-D stated memory care residents and families were not involved or asked for input on meal planning. The USDA My Plate: A Guide dated September 1, 2022, indicates half of food plates should include fruits and vegetables. The licensee's Menu and Recipes policy dated September 1, 2018, indicated the current menu was posted in the resident common areas and menus were modified as applicable to comply with state regulations. In addition, menus were planned in advanced and reviewed by the dietitian for nutritional adequacy. No further information provided.	0 485		

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	30762	A. BUILDING: _____ B. WING _____	12/27/2022

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0 485	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the	0 490		

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0 490	Continued From page 22 community at large. This had the potential to affect all residents of the licensee. 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: On December 20, 2022, from 6:40 a.m. to 10:38 a.m., the surveyor observed no activities provided to the residents on the Bluebird memory care unit and Hummingbird memory care unit (all male dementia unit). Residents were sitting at the dining room tables, wandering common areas, or were in rooms. On December 21, 2022, between 6:30 a.m. to 11:00 a.m., the surveyor observed no activities provided to the residents on the Hummingbird memory care unit. At 10:37 a.m., the surveyor observed the activity board, the undated schedule posted indicated breakfast no time included, lunch no time included, and piano Christmas tunes from 10:00 a.m.-10:30 a.m. On December 21, 2022, at 10:38 a.m., unlicensed personnel (ULP)-E stated the schedule posted was from the previous day. ULP-E stated that there was not much scheduled in the Hummingbird neighborhood and the piano tunes were on another unit. ULP-E also stated staff sometimes escorts the residents to other neighborhoods (units) for activities.	0 490		

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0 490	Continued From page 23 On December 21, 2022, at 10:45 a.m., R19 stated activities on the unit did not happen often, as the staff treat the men "like they are crazy," and most activities were on other units. R19 stated there was Christmas music the previous day on another neighborhood and they were taken to attend the activity. R19 further stated they are taken to the other neighborhood occasionally to play bingo with the ladies. On December 21, 2022, from 9:56 a.m. to 11:58 a.m., the surveyor observed no activities provided by the licensee's staff to the residents who resided on the Bluebird memory care unit. Visitor (V)-Q played guitar to a resident at the dining room table from 10:45 to 11:15 a.m. Residents were sitting at the dining room table with nothing in front of them, wandering the common area, fidgeting with items in their rooms, or sleeping. On December 21, 2022, at 11:21 a.m., V-Q stated they were at the facility to provide music therapy for one resident in the Bluebird memory care unit. On December 21, 2022, at 11:23 a.m., the surveyor observed an undated activity board which indicated 10:45a.m. to 11:30 a.m. piano music would be completed. On December 21, 2022, at 11:52, ULP-N stated the activity board was from December 20, 2022, and activity staff updated the board at 11:00 a.m. daily. In addition, ULP-N stated ULPs assisted with activities and provided television, played music, and if staff were able, would play cards between activities. On December 22, 2022, at 3:34 p.m., RN-A	0 490		

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0 490	Continued From page 24 verified on this day there were no activities in the Hummingbird neighborhood. RN-A stated the activities director updates the white boards with the daily activities. RN-A stated activities would be provided to all the neighborhoods when staff are available. The licensee's Calendar Requirements policy dated August 1, 2018, indicated all residents would have a sufficient number and variety of programs available to meet their interests, preferences, and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to	0 510		

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0 510	Continued From page 25 comply with acceptable health care, medical, and nursing standards for infection control. This deficient practice 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CARES On December 20, 2022, at 7:54 a.m., the surveyor observed unlicensed personnel (ULP)-P assist R2 with incontinent pull up removal. Without removing soiled gloves and performing hand hygiene, ULP-P placed an incontinence pull up, dressed R2's lower body and upper body, provided peri (perineal) care and wiped R2 from front to back however, used same area of wash cloth with each swipe. Without removing soiled gloves and performing hand hygiene, ULP-P completed dressing R2 by raising all clothing items on lower extremities, completed oral cares, and groomed R2's hair. On December 22, 2022, at 8:30 a.m., the surveyor observed R21's clothes soiled with stool, including his hands and face. R21 paced up and down the hallway saying "it is a mess", touching surfaces including tables, medication cart, counters and other residents; however, the surveyor observed no ULP present to immediately assist R21. At 8:45 a.m., ULP-E	0 510		

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0 510	Continued From page 26	0 510		

came from another resident's room and took R21 for a shower. The surveyor did not observe ULP-E immediately sanitize the touched surfaces or call another staff member to do so.

On December 22, 2022, at 9:00 a.m., ULP-E stated handing washing is completed when hands are soiled, before and after medication administration, and before touching foods. ULP-E also stated they may not know what surfaces the residents touched and every shift staff sanitize all touchable surfaces in the unit.

MEDICATION PASS
On December 20, 2022, at 6:50 a.m., the surveyor observed ULP-E set the dining tables for breakfast. At 6:58 a.m., ULP-E prepared and administered medications to R5 before completing hand hygiene.

On December 20, 2022, between 7:02 a.m. and 7:15 a.m., the surveyor observed ULP-E administer medications to R4, R20, and R21. ULP-E did not perform hand hygiene between resident medication administration.

On December 20, 2022, at 7:19 a.m., the surveyor observed ULP-N complete blood glucose monitoring on R17 then exit R17's room and proceed into the hallway with gloves on. ULP-N did not remove gloves until lancet and test strip was removed at the medication cart and placed into the sharps container.

On December 20, 22, at 7:39 a.m., the surveyor observed no hand hygiene completed between R15 and R18's medication administration by ULP-N.

On December 20, 2022, at 8:06 a.m., the

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0 510	Continued From page 27 surveyor observed ULP-N complete blood glucose monitoring and insulin administration on R2 then exited R2's room and proceeded into the hallway with gloves on. ULP-N did not remove gloves until lancet, needle, and test strip were removed at the medication cart and placed into the sharps container. On December 21, 2022, at 11:39 a.m., ULP-N stated they were trained to perform hand washing every three medication passes and sanitizer would be applied in-between each medication pass. In addition, ULP-N stated blood glucose supplies and insulin needles were disposed of in the sharps container at the cart and they were unaware gloves could not be worn in hallways. DINING ROOM On December 20, 2022, at approximately 7:45 a.m., during breakfast in a common area, the surveyor observed dietary (D)-D performed no hand hygiene prior to serving beverages and meals to six residents. On December 20, 2022, at 8:06 a.m., D-D applied gloves, served one resident food and drink, retrieved several items from cupboard and drawers, then served two additional residents before removing gloves and preforming hand hygiene. On December 21, 2022, at 11:35 a.m., during lunch in a common area, the surveyor observed ULP-C and ULP-J performed no hand hygiene prior to serving beverages and meals to ten residents. On December 22, 2022, at 3:52 p.m., RN-A stated all employees are supposed to complete hand hygiene frequently and especially before	0 510		

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0 510	Continued From page 28 and after administering medications and serving food. The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 8, 2021, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. The licensee's Hand Washing policy dated January 1, 2017, indicated proper hand washing/hygiene technique must be used at all times when indicated. The policy also indicated the use of gloves does not eliminate the need to wash hands and alcohol based hand rub can be used too. The licensee's Infection Prevention and Control Program dated October 1, 2018, indicated team members were to apply standard precautions and principles to patient [resident] care, adhere to infection prevention and control policies and procedures, and maintain a clean safe environment. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an	0 630		

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0 630	Continued From page 29 individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include all required content for two of five residents (R4, 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) 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: R4 R4 was admitted to the licensee November 3, 2020, and started receiving assisted living services August 1, 2021. R4's diagnoses included dementia, fracture of one rib, unspecified major depressive disorder, and hyperlipidemia. R4's service plan dated November 20, 2022, indicated R4 received services to include: medication administration, elopement behaviors, fall risk, bathing assistance, dressing, grooming,	0 630		

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0 630	Continued From page 30 housekeeping, laundry, ambulation, dining/eating assistance, transfer, and toileting assistance. R4's Vulnerability Assessment dated November 3, 2022, identified vulnerabilities to include lack of orientation to time, place, person, verbal abuse, and inability to use telephone. R4's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to R4 and other vulnerable adults. R5 R5 was admitted to the licensee May 19, 2021, and started receiving assisted living services August 1, 2021. R5's diagnoses include Alzheimer's disease unspecified, muscle weakness, and repeated falls. R5's unsigned service plan dated May 19, 2021, indicated R5 received services to include: medication administration, behavior management, fall risk, bathing assistance, dressing, grooming, housekeeping, laundry, transfer, and toileting assistance. R5's Vulnerability Assessment dated May 19, 2022, identified vulnerabilities to include lack of orientation to time, place, person, physical violence, and inability to ambulate safely. R5's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to R5 and other vulnerable adults. On December 22, 2022, at 3:47 p.m., registered nurse (RN)-A indicated the vulnerability assessments for R4 and R5 serve as the IAPP. RN-A acknowledged the IAPPs for R4 and R5 lacked the specific measures to be taken to	0 630		

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0 630	Continued From page 31 minimize the risk of abuse to that person and other vulnerable adults. The licensee's undated Abuse, Neglect and Exploitation Prohibition and Prevention Program policy indicated the licensee will ensure each resident is free from abuse, neglect and exploitation by anyone, but not limited to including staff, other residents, family members, friends or other individuals. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (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	0 650		

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0 650	Continued From page 32 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency documentation was maintained for one of two unlicensed personnel ((ULP)-C) 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) 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-C was hired on February 2, 2018, under the comprehensive license and started providing assisted living services August1, 2021. ULP-C's record lacked documentation of completed training for the following topics: - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and	0 650		

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0 650	Continued From page 33 - recognizing physical, emotional, cognitive, and developmental needs of the resident. On December 21, 2022, at 10:00 a.m., registered nurse (RN)-A indicated ULP-C's record lacked documentation of the required training. RN-A stated the training was completed in all required topics but could not locate them in the licensee system. The licensee's Training and Evaluation of Unlicensed Personnel policy dated August 1, 2019, indicated ULPs were instructed and evaluated on set items as required by Minnesota law and unlicensed personnel undergo instruction and competency evaluations as part of their employment with the licensee. In addition, training and competency evaluations for all unlicensed personnel would include the content listed above. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced	0 700		

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0 700	Continued From page 34 by: Based on observation, interview, and record review, the licensee failed to ensure residents' personal health and medical information was kept private. This had the potential to affect all residents on the Bluebird memory care unit and three of three residents (R15, R16, R20) on the Hummingbird memory care unit. 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 December 20, 2022, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-C left a computer open and unattended in the common area for five minutes to tend to other tasks on unit with R1's electronic medical record on the screen. There were four wandering residents in the common area. On December 20, 2022, at 7:05 a.m., the surveyor observed ULP-H complete cares on R20. The surveyor requested to know what morning cares R20 received and how to get that information. ULP-H stated they look in the hospice binders. ULP-H led surveyor to the binders at the desk of Hummingbird memory care unit. The surveyor observed four hospice binders, not locked and kept by the unattended desk in the open for anyone to look through. On December 21, 2022, at 10:35 a.m., the	0 700		

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	30762	A. BUILDING: _____ B. WING _____	12/27/2022

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0 700	Continued From page 35 surveyor observed unlocked cabinet that contained R15 and R16's hospice binders, which included nursing, social work, and chaplain progress notes. In addition, a binder titled Bridge to Rediscovery resident life review contained eight residents which included personal information including behavior triggers. On December 22, 2022, at approximately 3:34 p.m., registered nurse (RN)-A stated staff are expected to shut down their computer screens anytime that they walk away from their computer. RN-A further stated the licensee did not have a locked space for the hospice binders but will work to remove them as soon as possible from the units to one location in the nursing office for privacy. The licensee's Medical Records policy dated August 1, 2020, indicated medical records were maintained in accordance with Health Insurance Portability and Accountability Act (HIPPA) guidelines, federal and state regulations, accepted professional standards of practice, and company policies. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of	0 730		

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0 730	Continued From page 36 the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or	0 730		

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0 730	Continued From page 37 status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document services that had been provided as identified in the service plan for one of five 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 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: R7 was admitted to licensee and started receiving assisted living with dementia care services on October 26, 2022. R7's diagnoses included type two diabetes, osteoarthritis (a form of arthritis that affects joints in the hand, spine, knees and hips.), fracture of sacrum, T8 compression fracture (fracture of the spine that can cause your vertebrae to collapse making them shorter), and an associated osteophyte (bone spur) fracture. R7's service plan dated November 1, 2022, indicated R7 received assistance with medication administration, catheter care, bathing assistance, dressing, grooming, housekeeping, laundry, ambulation, dining/eating assistance, transfer, and toileting assistance.	0 730		

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0 730	Continued From page 38 On December 21, 2022, at 3:54 p.m., the surveyor observed unlicensed personnel (ULP)-I, empty urine from R7's catheter leg bag into a container used to measure urine output. ULP-I discarded the urine in the toilet and assisted in repositioning the leg bag on R7. R7's record lacked a provider order and lacked documentation of specific catheter care being provided to R7. On December 21, 2022, at 3:54 p.m., ULP-I stated they knew what cares to do because they always did them, though there was no place to document because nothing is noted in the electronic medication administration record (EMAR) or electronic treatment administration record (ETAR). On December 21, 2022, at 4:14 p.m., registered nurse (RN)-B stated catheter cares are done one time per shift and as needed, leg bags are changed from night bags to leg bags, and leg bags to night bags, and cleaned with vinegar and water each day, and everything is documented in the EMAR/ETAR. On December 22, 2022, at 9:55 a.m., RN-A stated, that for R7, "hospice has been helping us with the catheter, but I don't know what they all are doing and if it has been changed because we do not have orders." The licensee's Medical Records policy dated August 1, 2020, indicated medical records were kept current, complete, accurate, and readily accessible. No further information was provided.	0 730		

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0 730	Continued From page 39 TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and 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 regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on December 27, 2022, at approximately 11:00 a.m. with maintenance	0 800		

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0 800	Continued From page 40 assistant (MA)-R, it was observed that the bathroom exhaust fans in all the resident rooms were not working. During interview MA-R stated that he was not aware that the bathroom exhaust fans were not working and that he would check into why they are not working. No further information provided. 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 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	0 810		

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0 810	Continued From page 41 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 the required documentation of employee and resident training on fire safety and evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on December 27, 2022, at approximately 11:45 a.m. with registered nurse (RN)-A and maintenance assistant (MA)-R on the fire safety and evacuation training, and evacuation drills for the facility. 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	0 810		

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0 810	Continued From page 42 initial hire. During interview, RN-A stated that the licensee policy is to train employees on fire safety and evacuation annually after initial hire but did not have the documentation to back this up. 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. A policy was in place on resident training for fire safety and evacuation but there was no documentation that this training is being done. Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. During interview, RN-A stated that licensee has conducted evacuation drills for the employees to date at the time of survey but there was no documentation to back this up. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided	0 900		

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0 900	Continued From page 43 directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content post 144G Statute for five of five residents (R1, R2, R4, R7, R8). 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	0 900		

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0 900	Continued From page 44 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee converted to an Assisted Living Facility with Dementia Care license on August 1, 2021. The licensee failed to provide the Office of Ombudsman for Long-Term Care a complete, unsigned copy of its contract as required. R1 R1 admitted to the licensee January 27, 2015, and started receiving assisted living services August 1, 2021. R1's record included a Residency Agreement dated January 27, 2015. R2 R2 admitted to the licensee August 1, 2019, and started receiving assisted living services August 1, 2021. R2's record included a Residency Agreement dated July 28, 2018. R4 R4 admitted to the licensee November 3, 2020, and started receiving assisted living services August 1, 2021. R4's record included a Residency Agreement dated November 3, 2020. R7	0 900		

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0 900	Continued From page 45 R7 admitted to the licensee October 26, 2022. R7's record included a Residency Agreement dated October 26, 2022. R8 R8 admitted to the licensee July 25, 2022. R8's record included a Residency Agreement dated July 25, 2022. R1, R2, R4, R7, and R8's did not receive the required post 144G Statute contract to be provided to residents prior to providing housing or assisted living services. On December 22, 2022, at 3:50 p.m., registered nurse (RN)-A stated the licensee was using a pre-August 1, 2021 (the date Minnesota Statute 144G was implemented), contract for all the residents. RN-A stated the contract had not been updated as the licensee thought it was sufficient to meet the requirements of the assisted living statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
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	01060		

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01060	Continued From page 46 facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based interview and record review, the licensee failed to ensure a notice with required content was provided to the resident/representative for one of one resident (R14) who had an emergency	01060		

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01060	Continued From page 47 relocation out of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R14 R14 was admitted to the licensee for services on May 27, 2022. R14's Service Plan dated October 18, 2022, indicated R14 received medication administration, anticoagulant therapy, dressing, grooming, ambulation, transfers, reassurance checks, housekeeping, assistance with transfers, and laundry services. R14's Discharge Summary dated October 14, 2022, indicated that R14 had an emergency relocation to the hospital from September 26, 2022, following a sharp pain in lower abdomen. R14 returned to the licensee on October 14, 2022, after staying in the hospital for 19 days. Although R14 was relocated from the facility for 19 days (September 26 through October 14), R14's records lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice as required. On December 22, 2022, at 2:40 p.m., registered nurse (RN)-A stated the licensee had not	01060		

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01060	Continued From page 48 provided to the resident/resident representative or to the ombudsman office the required notices for emergency relocation. RN-A further stated the licensee was not aware of the requirement to do emergency relocation notices. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for three of five employees (unlicensed personnel (ULP)-C, ULP-E, ULP-H). This practice resulted in a level two violation (a	01290		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSTEAD OF ROGERS	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

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01290	Continued From page 49 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C began employment with the licensee February 27, 2018, under the comprehensive license and started providing assisted living services August 1, 2021. On December 21, 2022, at 11:35 a.m., the surveyor observed ULP-C provide meals and beverages to residents. ULP-C's employee record contained a background study dated February 26, 2021, affiliated to licensee's former health facility identification number (HFID) 20700. ULP-C's employee record lacked evidence the licensee submitted a background study for ULP-C under the current license and affiliated to the current HFID number. ULP-E ULP-E began employment with the licensee April 26, 2021, under the comprehensive license and started providing assisted living services August 1, 2021. On December 20, 2022, between 6:40 a.m. and 8:30 a.m., the surveyor observed ULP-E pass medications to the licensee's residents in the Hummingbird memory care unit.	01290		

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01290	Continued From page 50 ULP-E's employee record contained a background study dated March 22, 2021, affiliated to licensee's former HFID 20700. ULP-E's employee record lacked evidence the licensee submitted a background study for ULP-E under the current license and affiliated to the current HFID number. ULP-H ULP-H began employment with the licensee October 13, 2020, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-H's employee record contained a background study dated October 1, 2020, affiliated to licensee's former HFID 20700. ULP-H's employee record lacked evidence the licensee submitted a background study for ULP-H under the current license and affiliated to the current HFID number. On December 22, 2022, at 4:15 p.m., regional director (RD)-G stated licensee had not affliated ULP-C, ULP-E, and ULP-H's employee background to the current license. The licensee's Abuse, Neglect, and Exploitation Prohibition and Prevention policy dated November 15, 2002, indicated all prospective employees undergo a background-screening process in accordance with Human Resources policies and procedures and applicable law. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

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01420	Continued From page 51	01420		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure unlicensed personnel (ULPs) were trained in the proper methods to perform the tasks or procedures and were able to demonstrate the ability to competently follow the procedures and perform the tasks to a registered nurse (RN) for one of one ULP (ULP-C) who performed delegated tasks. 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).	01420		

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01420	Continued From page 52 The findings include: ULP-C started employment with the licensee on February 27, 2018, under the comprehensive license, and began providing services on August 1, 2021, under the assisted living license. Resident (R)-14's medication administration record (MAR) dated December 1, 2022, through December 31, 2022, indicated ULP-C provided R14's catheter cares, which included change from overnight bag to leg bag in the morning, change from leg bag to overnight bag, clean leg bag with vinegar and water mixture, and empty every shift and as needed, 34 times in the month of December 2022. On December 21, 2022, at 4:14 p.m., RN-B stated the orientation training was completed by a staffing coordinator or licensed practical nurses (LPNs) and competencies were completed by the LPNs. On December 21, 2022, at 4:34 p.m., RN-A stated competencies were previously completed by a former RN until approximately September 2021, and later, the LPN assisted with competency testing. RN-A stated, "The LPN doesn't usually sign off she does the competency testing, she just does them and then updates the RN when they are done." On December 22, 2022, at 10:16 a.m., ULP-C stated they were trained and "tested out" by LPN-K on colostomy bags, blood glucose, hand washing and "everything" by attending a class led by LPN-K, followed by shadowing, and demonstrating back to LPN-K.	01420		

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01420	Continued From page 53 The licensee's RN Delegation policy dated August 1, 2019, indicated a RN may delegate nursing services to a ULP that had demonstrated to the RN the ability to competently follow the procedures for the client [resident] and possess the knowledge and the skills consistent with the complexity of the task. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420		
01440 SS=F	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 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.	01440		

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01440	Continued From page 54 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 task was delegated for one of two unlicensed personnel ((ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C started employment with the licensee on February 27, 2018, under the comprehensive license, and began providing services on August 1, 2021, under the assisted living license. On December 20, 2022, at 7:12 a.m., the surveyor observed ULP-C obtain vital signs on R13. ULP-C's employee record lacked direct supervision performing delegated tasks provided within 30 calendar days after the date on which the ULP-C first performed the delegated tasks for residents and thereafter as needed based on performance. On December 20, 2022, at 12:00 p.m., registered nurse (RN)-A acknowledged ULP-C's record lacked documentation of supervision by the RN	01440		

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01440	Continued From page 55 within 30 calendar days from the date of first performing a delegated task and thereafter as needed based on performance. RN-A stated the 30-day supervisions would not be available in all ULPs records for performing delegated tasks as the RN was busy with other duties. The licensee's RN Delegation policy dated August 1, 2019, indicated a RN must provide direct supervision of staff performing the delegated tasks within 30 days after the individual begins working for the licensee and within 30 days after the individual begins performing delegated tasks after not performing delegated tasks for one year or longer. No further information 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; (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	01470		

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01470	Continued From page 56 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 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.	01470		

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01470	Continued From page 57 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of three employees (registered nurse (RN)-B, unlicensed personnel (ULP)-C), received orientation to assisted living facility licensing requirements before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: RN-B RN-B had a hire date of August 15, 2022, to provide direct care to the residents. On December 21, 2022, at 4:35 p.m., the surveyor observed RN-B obtain an oxygen saturation level on R3. RN-B's employee record lacked evidence to indicate RN-B had received orientation on the required following topics: - overview of assisted living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - consumer advocacy services;	01470		

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01470	Continued From page 58 - review of types of assisted living services the employee would provide and providers scope of license; and - principles of person-centered planning / service delivery. ULP-C ULP-C started employment with the licensee on February 27, 2018, under the comprehensive license, and began providing services on August 1, 2021, under the assisted living license. On December 20, 2022, at 7:12 a.m., the surveyor observed ULP-C obtain vital signs on R13. ULP-C's employee record lacked evidence to indicate ULP-C had received orientation on the required following topics: - an overview of assisted living statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - reporting maltreatment of vulnerable adults or minors; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01470		

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01470	Continued From page 59 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 - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On December 22, 2022, at 4:30 p.m., RN-A verified ULP-C's record lacked orientation to assisted living licensing requirements and regulations. RN-A stated ULP-C had completed orientation before providing assisting living services but was not able to locate the record. The licensee's Orientation policy dated January 1, 2003, indicated the licensee provided a comprehensive general orientation program for all newly hired and rehired team members within the first ten days of their employment/reemployment. The licensee's Orientation policy dated August 19, 2019, did not address the requirements of current licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another	01500		

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01500	Continued From page 60 source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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	01500		

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01500	Continued From page 61 and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the 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 interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-C). 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-C started employment with the licensee on February 27, 2018, under the comprehensive license, and began providing services on August 1, 2021, under the assisted living license. ULP-C's employee record included training on infection control techniques for one hour and principles of person-centered planning/service	01500		

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01500	Continued From page 62 delivery for one hour. ULP-C's employee record lacked at least eight hours of annual training for each 12 months of employment in the following topics: - training on reporting of maltreatment of vulnerable adults; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and On December 21, 2022, at 12:04 p.m., registered nurse (RN)-A stated the licensee's education department assigns all annual education training topics to employees through the online system at beginning of every year. RN-A further stated it was her understanding that employees had until December 31 to complete annual training. In addition, RN-A stated was not sure if all employees had completed their annual training. The licensee's Orientation policy dated August 1, 2019, indicated all team members must complete at least eight hours of annual training. The policy further indicated all missed topics would be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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	30762	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSTEAD OF ROGERS	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

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01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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 interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for one of three employees (unlicensed personnel (ULP)-C). 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:	01540		

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01540	Continued From page 64 The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective August 1, 2022, through September 20, 2023. ULP-C started employment with licensee on February 27, 2018, under the comprehensive license, and began providing services on August 1, 2021, under the assisted living license. ULP-C's training and orientation records dated August 20, 2018, indicated ULP-C had completed problem solving with challenging behaviors, but no time duration was assigned to the topic. ULP-C's employee record lacked at least eight hours of initial training on the following required topics within 80 working hours of the employment start date: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. On December 22, 2022, at 4:05 p.m., registered nurse (RN)-A verified ULP-C's employee record lacked documentation of eight hours of dementia care education. RN-A stated no further dementia care documentation was available for ULP-C. The licensee's Dementia Training policy dated August 1, 2003, indicated every staff had a basic understanding of the nature of Alzheimer's disease, dementia, and related disorders. In addition, staff were trained in the care of persons with dementia using training modules on dementia.	01540		

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01540	Continued From page 65 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=G	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 review, the licensee failed to ensure the registered nurse (RN) conducted a	01620		

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01620	Continued From page 66 comprehensive re-assessment following a change of condition for one of one resident (R3). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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: R3 was admitted to the licensee on March 7, 2022. R3 signed on with an outside agency for hospice (end of life) services on July 13, 2022. R3's Resident Evaluation dated July 13, 2022, indicated R3 was receiving hospice care. The assessment indicated there were no wounds present. On December 21, 2022, at approximately 4:09 p.m., the surveyor observed a wound on R3's left foot, third toe, which appeared to be an arterial wound (an ulcer caused by poor circulation), and was approximately 1 centimeter (cm) x 1.5 cm, 80 percent slough (yellow or white material in the wound bed consisting of dead cells), 20 percent granulation tissue (new connective tissue and microscopic blood vessels that form on the surface of a wound during healing) with a pinpoint of bone exposure, wound edges approximated (the wound would appear closed if the edges were pulled together), peri wound macerated (the skin surrounding the wound is too moist and	01620		

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01620	Continued From page 67	01620		

vulnerable to breakdown), serosanguineous drainage (thin, watery fluid that is pink in color due to the presence of red blood cells) present. R3's right foot had six arterial wounds, one to the great toe, three to the second toe, one to the middle toe, and one to the pinky toe. Four of the arterial wounds wound beds were 100 percent unstable eschar (a collection of dry, dead tissue that becomes wet, loose, or boggy requiring debridement) with purulent drainage (white, yellow or brown thicker drainage that is a sign of infection) noted. One wound was 100 percent stable eschar with no drainage. Right middle toe had an area black in color however, had not opened.

R3's Resident Evaluation signed December 14, 2022, indicated R3 had one wound site that required wound care. The assessment lacked site location and description of the wound.

R3's unsigned service plan with a print date of December 21, 2022, included heel protectors daily after application of Aquaphor to the heels and intact areas of the foot, and paint toes daily on right foot with betadine. The service plan lacked information related to the wound on R3's left foot.

R3's Progress Notes dated September 26, 2022, through December 15, 2022, lacked information regarding R3's wound to left foot.

The surveyor reviewed R3's hospice nursing progress notes, Hospice IDG Comprehensive Assessment and Plan of Care Updates, and provider orders from August 15, 2022, to December 15, 2022. The documents indicated hospice managed an unspecified amount of wound on the right foot, however, did not indicate

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01620	Continued From page 68 hospice was aware of or was managing care of a wound to the left foot. R3's electronic medical record (EMAR) dated December 1, 2022, through December 31, 2022, included paint necrotic areas on right foot daily. Keep socks off, but wear heel booties. The entire month of December had an "X" in the documentation section. On December 21, 2022, at 1:16 p.m., RN-A stated hospice had a binder they were able to utilize for communication however, they normally spoke verbally to coordinate cares. On December 21, 2022, at 1:18 p.m., the surveyor inquired if the licensee completed the wound care treatment for R3's right foot at the facility. RN-A stated she was unclear about who was responsible for wound care to R3 however, hospice notes indicated hospice had been managing treatment to the right lower extremity. RN-A stated, "I think we are supposed to be doing that, yes." On December 21, 2022, at 1:20 p.m., the surveyor inquired what the "X" meant on the EMAR related to the right foot treatment order. RN-A stated the "X" meant it was not completed. On December 21, 2022, at 1:21 p.m., RN-A stated R3's assessment and service plan would reflect R3's wounds and treatments. Following the surveyor's inquiry as to the number of wounds R3 currently had, RN-A looked at documentation and stated one to the right foot. The surveyor inquired if RN-A was aware of the wound on R3's left third toe. RN-A stated they were not aware of the wound on the left foot. In addition, RN-A stated they would be updated by staff on any new	01620		

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01620	Continued From page 69	01620		

areas of concern to a resident or when they complete an assessment.

The licensee's Resident Assessment and Re-Assessment Process dated April 1, 2019, indicated existing resident are assessed or re-assessed in accordance with state laws and regulation and /or change in status.

No further information was provided.

TIME PERIOD FOR CORRECTION: IMMEDIATE

An immediate correction order was issued for 1620 on December 22, 2022, at 4:28 p.m. Immediacy is removed by evaluation supervisor review on December 27, 2022, however noncompliance remains at a scope and severity of G.

In addition, the licensee failed to ensure a RN conducted a reassessment, not to exceed 14 calendar days after the initiation of services for two of five residents (R3, R7) and failed to ensure the RN conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of five residents (R1, R3).

The findings include:

14-DAY
R3
R3 was admitted to the licensee for assisted living services on March 7, 2022.

R3's diagnoses included aortic stenosis (hearts aortic valve narrows), cardiomyopathy (disease of the heart muscle which makes it difficult for the heart to pump blood to other parts of the body),

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01620	Continued From page 70 congestive heart failure (CHF), and mild cognitive impairment. R3's service plan signed on August 28, 2022, indicated R3 received assistance with housekeeping, laundry, transfers, bathing, grooming, dressing, meals, activities, medication administration, behavior management, and toileting. R3's unsigned service plan printed December 21, 2022, indicated R3 received oxygen management. R3's record included a 14-day assessment titled Senior Living Resident Evaluation dated April 1, 2022, 25 days after R3 admitted to the licensee. R7 R7 was admitted to the licensee for assisted living services on October 26, 2022. R7's diagnoses included type two diabetes, osteoarthritis (a form of arthritis that affects joints in the hand, spine, knees and hips.), fracture of sacrum, T8 compression fracture (fracture of the spine that can cause your vertebrae to collapse making them shorter), and an associated osteophyte (bone spur) fracture. R7's service plan dated November 1, 2022, indicated R7 received assistance with medication administration, catheter care, fall risk, bathing assistance, dressing, grooming, housekeeping, laundry, ambulation, dining/eating assistance, transfer, and toileting assistance. R7's record included a Resident Evaluation dated October 26, 2022, and lacked further assessments including a 14-day assessment.	01620		

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01620	Continued From page 71 On December 28, 2022, RN-A stated via email correspondence at 11:24 a.m., "When the resident was initially hospitalized, she resided in the assisted living (AL) building at 20500 [a different assisted living licensee] and was receiving assisted living services. On October 26, 2022, the resident came back to the community but was moved into a memory care apartment in the 20600 building for assisted living with memory care services." On December 29, 2022, RN-A stated via email correspondence at 8:48 a.m., the October 26, 2022, resident evaluation was "the most recent eval," indicating the 14-day assessment was not completed. 90-DAY R1 R1 was admitted to the licensee January 27, 2015, and started receiving assisted living services August 1, 2021. R1's diagnoses included dementia without behavioral disturbances, gastrointestinal hemorrhage, hypertension (HTN), and edema. R1's service plan dated May 27, 2022, indicated R1 received assistance with medication administration, bathing assistance, dressing, grooming, housekeeping, laundry, ambulation, dining assistance, transfer, and toileting assistance. R1's record included a 90-day re-assessment titled Senior Living Resident Evaluation dated May 13, 2022, and September 14, 2022, indicating 124 days passed between re-assessments.	01620		

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01620	Continued From page 72 R3 R3 was admitted to the licensee for assisted living services on March 7, 2022. R3's diagnoses included aortic stenosis (hearts aortic valve narrows), cardiomyopathy (disease of the heart muscle which makes it difficult for the heart to pump blood to other parts of the body), congestive heart failure (CHF), and mild cognitive impairment. R3's service plan signed on August 28, 2022, indicated R3 received assistance with housekeeping, laundry, transfers, bathing, grooming, dressing, meals, activities, medication administration, behavior management, and toileting. R3's unsigned service plan printed December 21, 2022, indicated R3 received oxygen management. R3's record included a 14-day and 90-day re-assessment titled Senior Living Resident Evaluation dated April 1, 2022, and July 13, 2022, respectively, indicating 103 days passed since R3's 14-day assessment. On December 20, 2022, at 12:05 p.m., RN-A stated assessments were expected to be completed upon move in, 14-days, 90-days or with change of condition and could be completed early but should not exceed 90 days. In addition, RN-A stated, "I have no reason for them being late other than short staff." The licensee's Resident Assessment and Re-Assessment Process dated April 1, 2019, indicated existing resident are assessed or	01620		

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01620	Continued From page 73 re-assessed in accordance with state laws and regulation and/or change in status. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan	01640		

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01640	Continued From page 74	01640		

included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for three of five residents (R3, R5, R22).

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
R3 was admitted to the licensee for assisted living services on March 7, 2022.

R3's diagnoses included aortic stenosis (hearts aortic valve narrows), cardiomyopathy (disease of the heart muscle which makes it difficult for the heart to pump blood to other parts of the body), congestive heart failure (CHF), and mild cognitive impairment.

R3's service plan signed on August 28, 2022, indicated R3 required assistance with ambulation with use of four wheeled walker (4WW), transfers with minimal assist of one, assist with bathing, physical assist with grooming, physical assist with dressing, medication management, and physical assist with toileting.

R3's unsigned service plan printed December 21, 2022, indicated R3 was dependent on staff for ambulation needs, assist of two with mechanical

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01640	Continued From page 75 lift for transfers, dependent on bathing, dependent on grooming, physical assistance with dressing, staff provided medication administration, oxygen management in coordination with hospice for supplies, end of life care, wound treatment to the right foot, and dependent for continence management. R5 R5 was admitted to the licensee May 19, 2021, and started receiving assisted living services August 1, 2021. R5's diagnoses include Alzheimer's disease unspecified, muscle weakness, and repeated falls. R5's unsigned service plan, dated May 19, 2021, indicated R5 required assistance with medication administration, behavior management, fall risk, bathing assistance, dressing, grooming, housekeeping, laundry, transfers, and toileting assistance. R22 R22 was admitted to the licensee March 18, 2020, under the comprehensive license, and started receiving assisted living services August 1, 2021. R22's diagnoses included Alzheimer's disease unspecified, type 2 diabetes mellitus, and hyperlipidemia. R22's unsigned service plan dated March 18, 2020, indicated R22 required assistance with medication administration, anticoagulant therapy, eating, grooming, bathing, wellness services, dressing, elopement management, fall risk, laundry, and housekeeping.	01640		

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01640	Continued From page 76 R3, R5, and R22's service plans lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided. On December 20, 2022, at 12:18 p.m., registered nurse (RN)-A stated they believed the process the licensee used to update the service plan was incorrect as the licensee did not obtain a signature from the resident or representative with each change made to the service plan. RN-A stated the licensee did not obtain a signature with each revision to the service plan and the licensee waited until an assessment was completed to obtain a signature from the resident or resident's designated representative. The licensee's Resident Service Plans policy dated April 1, 2019, indicated the licensee's service plans adheres to state-specific laws, regulations and guidelines including time frames with regards to the provisions and procedures set forth. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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;	01650		

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	30762	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSTEAD OF ROGERS	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

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01650	Continued From page 77 (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for six of six residents (R1, R2, R3, R4, R5, R7). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01650		

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01650	Continued From page 78 The findings include: R1 R1 was admitted to the licensee January 27, 2015, and started receiving assisted living services August 1, 2021. R1's service plan dated November 20, 2022, indicated R1 required assistance with medication administration, bathing assistance, dressing, grooming, housekeeping, laundry, ambulation, dining/eating assistance, transfer, and toileting assistance. R2 R2 was admitted to the licensee August 1, 2019, and started receiving assisted living services August 1, 2021. R2's service plan signed August 23, 2022, indicated R3 required assistance with ambulation, transfers, bathing, grooming, dressing, toileting, behavior management, meals, activities, medication management, and blood glucose monitoring by staff and/or PT/INR (blood thinner lab work) monitoring by staff. R3 R3 was admitted to the licensee for assisted living services on March 7, 2022. R3's service plan signed on August 28, 2022, indicated R3 required assistance with housekeeping, laundry, transfers, bathing, grooming, dressing, meals, activities, medication administration, behavior management, and toileting. R3's unsigned service plan printed December 21,	01650		

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01650	Continued From page 79 2022, indicated R3 received oxygen management. R4 R4 was admitted to the licensee November 3, 2020, and started receiving assisted living services August 1, 2021. R4's service plan dated November 20, 2022, indicated R4 required assistance with medication administration, elopement behaviors, bathing assistance, dressing, grooming, housekeeping, laundry, ambulation, dining/eating assistance, transfers, and toileting assistance. R5 R5 was admitted to the licensee May 19, 2021, and started receiving assisted living services August 1, 2021. R5's service plan dated May 19, 2021, indicated R5 required assistance with medication administration, behavior management, bathing assistance, dressing, grooming, housekeeping, laundry, transfers, and toileting assistance. R7 R7 was admitted to the licensee February 13, 2019, and started receiving assisted living services August 1, 2021. R7's service plan dated November 1, 2022, indicated R7 required assistance with medication administration, catheter care, bathing assistance, dressing, grooming, housekeeping, laundry, ambulation, dining/eating assistance, transfers, and toileting assistance. R1, R2, R3, R4, R5 and R7's service plan lacked the following required content:	01650		

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01650	Continued From page 80 - the schedule of monitoring assessments of the resident; and - the schedule and methods of monitoring staff providing services. On December 22, 2022, at 4:15 p.m., registered nurse (RN)-A verified R4 and R5's service plans were missing required content and the same service plan template was used for all licensee residents. The licensee's Resident Service Plans policy dated April 1, 2019, indicated the licensee's service plans adheres to state-specific laws, regulations and guidelines including time frames with regards to the provisions and procedures set forth. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and	01700		

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01700	Continued From page 81 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 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for six of six residents (R1, R2, R3, R4, R5, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 19, 2022, at 10:00 a.m., registered nurse (RN)-A confirmed the licensee provided medication management services to the licensee's residents.	01700		

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01700	Continued From page 82 The current resident roster provided during the entrance conference indicated 70 of 79 residents received medication management services. R1 R1's diagnoses included dementia without behavioral disturbances, gastrointestinal hemorrhage, hypertension (HTN), and edema. R1's service plan dated May 27, 2022, indicated R1 received medication management services which included medication administration. On December 20, 2022, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-C administer levothyroxine sodium 50 microgram (mcg) tablet in applesauce to R1 per the electronic medication administration record (EMAR). R2 R2's diagnoses included Alzheimer's disease, diabetes type two, and mixed incontinence. R2's service plan signed August 23, 2022, indicated R3 received assistance with ambulation, transfers, bathing, grooming, dressing, toileting, behavior management, meals, activities, medication management, and blood glucose monitoring by staff and/or PT/INR (blood thinner lab work) monitoring by staff. On December 20, 2022, at 8:22 a.m., the surveyor observed ULP-N administer insulin to R2. R3 R3's diagnoses included aortic stenosis (hearts aortic valve narrows), cardiomyopathy (disease of the heart muscle which makes it difficult for the	01700		

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01700	Continued From page 83 heart to pump blood to other parts of the body), congestive heart failure (CHF), and mild cognitive impairment. R3's service plan signed on August 28, 2022, indicated R3 received assistance with housekeeping, laundry, transfers, bathing, grooming, dressing, meals, activities, medication administration, behavior management, and toileting. R4 R4's diagnoses included dementia and fracture of one rib. R4's service plan dated November 20, 2022, indicated R4 received assistance with medication administration, elopement behaviors, bathing assistance, dressing, grooming, housekeeping, laundry, ambulation, dining/eating assistance, transfers, and toileting assistance. On December 20, 2022, at 8:20 a.m., the surveyor observed ULP-E administer medication to R4. R5 R5's diagnoses include Alzheimer's disease unspecified, muscle weakness, repeated falls, and chronic systolic heart failure. R5's service plan dated May 19, 2021, indicated R5 received assistance with medication administration, behavior management, bathing assistance, dressing, grooming, housekeeping, laundry, transfers, and toileting assistance. On December 20, 2022, at 8:50 a.m., the surveyor observed ULP-E administer medication to R5.	01700		

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01700	Continued From page 84 R7 R7's diagnoses included type two diabetes, osteoarthritis (a form of arthritis that affects joints in the hand, spine, knees and hips.), fracture of sacrum, T8 compression fracture (fracture of the spine that can cause your vertebrae to collapse making them shorter), and an associated osteophyte (bone spur) fracture. R7's service plan dated November 1, 2022, indicated R7 received medication management services which included medication administration. R1, R2, R3, R4, R5, and R7's record lacked evidence the RN had conducted a face-to-face assessment/review that included an identification and review of all medications the resident is known to be taking, indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On December 22, 2022, at 4:55 p.m., RN-A verified R1, R2, R3, R4, R5, and R7's resident records lacked an individualized medication assessment to include the content listed above. RN-A further stated they had other duties to do and that some other residents could be missing the same record. The licensee's Resident Self-Administration of Medication/Resident Medication Service Assessment policy dated April 1, 2019, indicated the director of resident care or designee would assess the resident's medication management needs and ability to self-administer upon move-in or at the resident's request, using the management service assessment.	01700		

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01700	Continued From page 85 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment when there was a change in the resident's medications for one of two residents (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 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: R3 was admitted to the licensee for assisted living services on March 7, 2022. R3's service plan signed on August 28, 2022,	01710		

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01710	Continued From page 86 indicated R3 received assistance with housekeeping, laundry, transfers, bathing, grooming, dressing, meals, activities, medication administration, behavior management, and toileting. R3's unsigned service plan printed December 21, 2022, indicated R3 received oxygen management and medication administration. R3's Order Summary Report dated December 19, 2022, included provider orders for acetaminophen 1000 milligrams (mg), Aquaphor ointment topical, aspirin enteric (EC), atropine sulfate ophthalmic solution 1 percent (%), biscolax rectal suppository 10 mg, bumex 1mg, Haldol 0.5 mg, morphine solutab 2.5 mg, ondansetron 4mg, sertraline 50 mg, and Zyprexa 2.5 mg with various order dates from April 22, 2022, through November 23, 2022. R3's electronic medication administration record (EMAR) dated December 1, 2022, through December 31, 2022, indicated R3 received the following medications: aspirin EC 81 mg, Bumex 1 mg, olanzapine 2.5 mg, sertraline 50 mg, Zyprexa 2.5 mg, and morphine solutab 2.5 mg. R3's record lacked evidence or reassessment for review of medications with changes in medication. On December 20, 2022, at 12:05 p.m., RN-A verified R3's record lacked a current medication administration evaluation. RN-A stated assessments were expected to be completed with changes of condition. In addition, RN-A stated, "I have no reason for them being late other than short staff." The licensee's Resident Self-Administration of	01710		

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01710	Continued From page 87 Medication/Resident Medication Service Assessment policy dated April 1, 2019, indicated the RN would complete a medication management re-assessment every 90 days or more, as needed, and when a resident presents with symptoms and other issues that may be medication related. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed	01730		

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01730	Continued From page 88 personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for five of five residents (R1, R2, R3, R4, 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) 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 December 20, 2022, at 12:18 p.m., registered	01730		

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01730	Continued From page 89	01730		

nurse (RN)-A stated the medication management plan was located in the service plan which included the document titled Senior Living Resident Evaluation and an untitled document referred to as plan of care.

R1
R1's service plan dated November 20, 2022, indicated R1 received assistance with medication administration, bathing assistance, dressing, grooming, housekeeping, laundry, ambulation, dining/eating assistance, transfers, and toileting assistance.

On December 20, 2022, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medication to R1.

R1's medication management plan lacked the content to include:
- procedures for staff to notify an RN when problems arose.

R2
R2's service plan signed August 23, 2022, indicated R3 needed assistance with ambulation, transfers, bathing, grooming, dressing, toileting, behavior management, meals, activities, medication management, and blood glucose monitoring by staff and/or PT/INR (blood thinner lab work) monitoring by staff.

On December 20, 2022, at 8:22 a.m., the surveyor observed ULP-N administer insulin to R2.

R2's medication management plan lacked the content to include:
- identification of the person responsible for monitoring medication supplies and ordering

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01730	Continued From page 90 refills on a timely basis; - identification of team members responsible for medication management tasks, including tasks delegate to unlicensed staff; and - the procedure for notifying the RN when there is a problem with any medication management service. R3 R3's service plan signed on August 28, 2022, indicated R3 received assistance with housekeeping, laundry, transfers, bathing, grooming, dressing, meals, activities, medication administration, behavior management, and toileting. R3's unsigned service plan printed December 21, 2022, indicated R3 received oxygen management and medication administration. R3's medication management plan lacked the content to include: - identification of team members responsible for medication management tasks, including tasks delegate to unlicensed staff. R4 R4's service plan, dated November 20, 2022, indicated R4 received assistance with medication administration, elopement behaviors, bathing assistance, dressing, grooming, housekeeping, laundry, ambulation, dining/eating assistance, transfer, and toileting assistance. On December 20, 2022, at 8:20 a.m., the surveyor observed ULP-E administer medication to R4. R4's medication management plan lacked the content to include:	01730		

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THE WELLSTEAD OF ROGERS	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

(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
01730	Continued From page 91 - procedures for staff to notify an RN when problems arose. R5 R5's service plan dated May 19, 2021, indicated R5 received assistance with medication administration, behavior management, bathing assistance, dressing, grooming, housekeeping, laundry, transfer, and toileting assistance. On December 20, 2022, at 8:050 a.m., the surveyor observed ULP-E administer medication to R5. R5's medication management plan lacked the content to include: - procedures for staff to notify an RN when problems arose. On December 22, 2022, at 4:55 p.m., RN-A verified R1, R2, R3 R4, and R5's medication management plans lacked content listed above. RN-A stated the content is included in all assessments and this was only missed in the process of writing the plans. The licensee's Resident Self-Administration of Medication/Resident Medication Service Assessment policy dated April 1, 2019, indicated if a resident needed or requested medication management services, the RN would develop a medication management individualized service plan that would include the following: - identification of the medication management services to be provided; - a description of how medications will be stored, based on the resident's needs, risk of diversion and consistent with manufacturer's directions; - identification of any specific instructions regarding the medications administered;	01730		

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01730	Continued From page 92 - identification of the person responsible for monitoring medication supplies and ordering refills on a timely basis; - identification of team members responsible for medication management tasks, including tasks delegate to unlicensed staff; - the procedure for notifying the RN when there is a problem with any medication management service; and - any resident specific requirements relating to documentation of medication administration, verification that all medications are administered as prescribed and monitoring of medication use to avoid possible complications or adverse reactions. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	01750		

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01750	Continued From page 93 Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the task of medication administration, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and verified the ULPs were able to demonstrate the ability to competently follow the procedure for three of four employees (ULP-C, ULP-I, ULP-J). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on February 27, 2018, under the comprehensive license, and began providing services on August 1, 2021, under the assisted living license. On December 20, 2022, between 7:15 a.m., and 8:00 a.m., the surveyor observed ULP-C administer medications to "Chickadee" memory care residents. ULP-C's employee record included a competency evaluation titled EduCare Knowledge & Skills Assessment Medication I Routes dated October 2, 2018, signed by RN-L. ULP-C's employee record included a competency evaluation titled Skill Competency Medication	01750		

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01750	Continued From page 94 Administration - Routes and Nebulizer & Inhaler dated October 11, 2019, which indicated licensed practical nurse (LPN)-K evaluated ULP-C's competency on oral, sublingual, buccal, topical, eye drops, eye ointment, ear drops, transdermal patch, nasal spray, vaginal, rectal and inhaler medication administration. Underneath LPN-K's signature and date on the competency form was an undated ink stamp of RN-A's signature. On December 22, 2022, at 10:16 a.m., ULP-C stated they were trained and "tested out" by LPN-K on medication administration by attending a class led by LPN-K, followed by shadowing and demonstrating back medication administration to LPN-K. ULP-I ULP-I was hired on July 18, 2019, under the comprehensive license, and began providing services on August 1, 2021, under the assisted living license. ULP-I's employee record included a competency evaluation titled Skill Competency Medication Administration - Routes and Nebulizer & Inhaler dated November 15, 2019, which indicated LPN-K evaluated ULP-I's competency on oral, sublingual, buccal, topical, eye drops, eye ointment, ear drops, transdermal patch, nasal spray, vaginal, rectal and inhaler medication administration. Underneath LPN-K's signature and date on the competency form was an undated ink stamp of RN-A's signature. ULP-J ULP-J was hired on March 12, 2017, under the comprehensive license, and began providing services on August 1, 2021, under the assisted living license.	01750		

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01750	Continued From page 95 ULP-J's employee record included a competency evaluation titled Skill Competency Medication Administration - Routes dated November 1, 2019, which indicated LPN-K evaluated ULP-J's competency on oral, sublingual, buccal, topical, eye drops, eye ointment, ear drops, transdermal patch, nasal spray, vaginal, rectal medication administration. Underneath LPN-K's signature and date on the competency form was an undated ink stamp of RN-A's signature. On December 21, 2022, at 4:14 p.m., RN-B stated the orientation trainings were completed by a staffing coordinator or LPN's and competencies were completed by the LPN's. On December 21, 2022, at 4:34 p.m., RN-A stated the licensee had LPNs assist with competency training for delegated tasks, but the RNs completed competency training for medications. However, RN-A stated competencies were previously completed by a former RN until approximately September 2021, and later, the LPN assisted with competency testing. RN-A stated, "The LPN doesn't usually sign off she does the competency testing, she just does them and then updates the RN when they are done." On December 22, 2022, at 10:25 a.m., ULP-J stated they were trained and "demonstrated I knew what to do" by LPN-K on medication administration by attending a two-day class led by LPN-K, followed by three days of "cart training" that consisted of LPN-K watching ULP-J administer medications at the medication cart. On December 22, 2022, at 1:56 p.m., RN-A stated ULP-I and ULP-J administered	01750		

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01750	Continued From page 96 medications to the residents at the facility. The licensee's RN Delegation policy dated August 1, 2019, indicated a RN may delegate nursing services to a ULP that had demonstrated to the RN the ability to competently follow the procedures for the client [resident] and possess the knowledge and the skills consistent with the complexity of the task. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed by evaluation supervisor review on December 27, 2022, however noncompliance remains at a scope and severity of I. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any 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.	01760		

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01760	Continued From page 97 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff administered scheduled medications as ordered for two of five residents (R7, R22). 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: R7 R7's diagnoses included type two diabetes, osteoarthritis (a form of arthritis that affects joints in the hand, spine, knees and hips.), fracture of sacrum, T8 compression fracture (fracture of the spine that can cause your vertebrae to collapse making them shorter), and an associated osteophyte (bone spur) fracture. R7's service plan dated November 1, 2022, indicated R7 received medication administration. R7's medication administration record (MAR) dated November 2022 and December 2022, indicated R7's physician ordered glipizide oral tablet 10 milligram (mg) by mouth one time a day related to type two diabetes mellitus without complications. R7's MAR indicated glipizide was scheduled for administration in the morning (AM). R7's November MAR dated November 1, 2022,	01760		

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01760	Continued From page 98 through November 30, 2022, and December MAR dated December 1, 2022, through December 31, 2022, indicated staff did not administer R7's glipizide doses as scheduled on the following dates: November 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 and December 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21, 2022. R7's Progress Notes dated November 30, 2022, through December 21, 2022, indicated glipizide was out of stock. R7's November MAR dated November 1, 2022, through November 30, 2022, and December MAR dated December 1, 2022, through December 31, 2022, indicated R7's physician ordered lidocaine external patch, apply to painful areas topically one time a day for pain. Apply in AM and remove after 12 hours. R7's November MAR dated November 1, 2022, through November 30, 2022, and December MAR dated December 1, 2022, through December 31, 2022, indicated staff did not administer R7's lidocaine external patch as scheduled on the following dates: November 9, 10, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 and December 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21, 2022. R7's Progress Notes dated November 30, 2022, through December 21, 2022, indicated lidocaine external patch was out of stock. R22 R22's diagnoses included Alzheimer's disease unspecified, type 2 diabetes mellitus, and	01760		

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01760	Continued From page 99 hyperlipidemia. R22's service plan dated March 18, 2020, indicated R22 was receiving medication administration, anticoagulant therapy, eating, grooming, bathing, and wellness services. R22's physician orders dated November 13, 2022, indicated R22 was prescribed to take vitamin B12 1000 microgram (mcg) by mouth daily. R22's December 2022 MAR indicated staff did not administer R22's vitamin B12 oral tablets 1000mcg as scheduled on the following dates: December 15, 16, 17, 18, 19, 20, 21, 22, 23, and 24, 2022. On December 20, 2022, at 8:40 a.m., ULP-E stated R22 was out of vitamin B12 1000 mcg and they had notified the RN through the communication system set in place. On December 22, 2022, at 9:55 a.m., RN-A stated they did not know the medications were out because staff never informed them [RN-A] to reorder the medications and the expectation when medications were out of stock was for staff to cut the top label off from the medication and give it to the nurses for re-ordering. The licensee's Medication Management Guidelines policy dated April 1, 2019, indicated omissions and/or refusals were documented on the electronic medication administration record (EMAR) and the director of resident care would be notified, interviews and/or assessment of the resident completed, and health care provider would be updated.	01760		

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01760	Continued From page 100 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely and permit only authorized personnel to have access for two of four medication carts. 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: On December 20, 2022, at 6:30 a.m., the surveyor observed the chickadee unit medication carts E and F that contained all medications for the chickadee unit residents. The carts were located in the common area, unlocked and	01880		

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01880	Continued From page 101 unattended, with push lock unsecured. The medication cart key was located in the unlocked open compartment of medication cart that stored cups. Unlicensed professionals (ULPs) were away from the carts, tending to other tasks around the unit. There were four wandering residents and seven residents sitting in chairs in the common area. On December 20, 2022, at approximately 8:10 a.m., registered nurse (RN)-A stated the medications in the cart should be locked when not attended by authorized staff. The licensee's Medication Management Guidelines policy dated April 1, 2019, indicated medications for residents receiving medication management were stored in appropriately lighted, locked storage area accessible to authorized personnel only. In addition, medication cabinets and carts were under visual control of staff at all times when in use and when not in use were locked. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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01890	Continued From page 102 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to date time-sensitive medications with an opened-on date and failed to ensure medications were labeled with residents' information for two of four medication carts. 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: On December 20, 2022, at approximately 6:46 a.m., the surveyor observed the contents of medication carts E and F and observed the following time sensitive medications were opened without an open label and/or medication without prescriptions labels: - one opened bottle of brimonidine tartrate ophthalmic solution 0.2 percent (%) with no pharmacy label, resident identifier. - two bottles of timolol maleate 0.5 % located in medication cart section labeled "drops" with no pharmacy label or resident identifier. One bottle was expired and labeled "OD [opened date] 08/26". - one expired bottle of Systane complete drops located in medication cart section labeled "drops" with no pharmacy label or resident identifier and labeled "Op. [opened] 2/12/22"; and - one bottle of folic acid 400 mcg labeled "2" and	01890		

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01890	Continued From page 103 "AM" with no pharmacy label or resident identifier. On December 20, 2022, at approximately 8:10 a.m., registered nurse (RN)-A confirmed all time sensitive medications and OTC medications including the above noted should be dated after opening with an open date and expiration date, and expired medications were expected to be checked and removed daily. RN-A stated the expectations were that all medications would have a pharmacy label or a resident label that is legible and would remain located in a locked storage like the cart or a locked drawer in the resident's bathroom. The manufacturer's instructions for the use of timolol maleate 0.5 % eye drops dated September 1, 2022, indicated use of eye drops should end within one month of being opened. The manufacturer's instructions for the use of Systane complete eye drops dated 2020, indicated use of eye drops should end within three months of being opened. The licensee's Medication Management Guidelines policy dated April 1, 2019, indicated medications were stored in an orderly manner in cabinets, drawers, or carts and no discontinued, outdated, or deteriorated drugs may be retained for use. In addition, medications were stored in the container in which they were received. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01900	Continued From page 104	01900		
01900 SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure a prescription medication supply for one resident was not being saved for use by another, other than the resident prescribed for one of one resident (R23). 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: R23's unsigned and undated service plan indicated R23 received medication management services. On December 20, 2022, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-E grab a prescription barrier cream from R24's side of the bathroom and used it on R23. The surveyor observed the phamarcy label on the tube and it confirmed the barrier cream was for R24. On December 22, 2022, at 4:23 p.m., registered nurse (RN)-A stated the licensee's policy does not allow sharing of medication. RN-A further stated	01900		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSTEAD OF ROGERS	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

(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
01900	Continued From page 105 ULPs are trained as soon the note a resident medication supply is running low, they need to notify the RN. The licensee's undated Resident Medication Services Assessment policy, indicated the RN was responsible for medication supplies and reodering in timely manner. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to	01940		

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01940	Continued From page 106	01940		

documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for two of two residents (R2, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R2
R2's service plan signed August 23, 2022, indicated R3 received assistance with ambulation, transfers, bathing, grooming, dressing, toileting, behavior management, meals, activities, medication management, and blood glucose monitoring by staff and/or PT/INR (blood thinner lab work) monitoring by staff.

R2's electronic medication administration record (EMAR) dated December 1, 2022, through December 21, 2022, included blood glucose check with meals and at bedtime - update

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01940	Continued From page 107 registered nurse (RN) if blood sugar is below 70 or above 400. On December 20, 2022, at 8:09 a.m., the surveyor observed unlicensed personnel (ULP)-N preform blood glucose monitoring on R2. R2's treatment plan lacked the following required content for blood glucose monitoring: - identification of treatment or therapy tasks that will be delegated to unlicensed personnel. R3 R3's service plan signed on August 28, 2022, indicated R3 received assistance with housekeeping, laundry, transfers, bathing, grooming, dressing, meals, activities, medication administration, behavior management, and toileting. R3's unsigned service plan printed December 21, 2022, indicated R3 received oxygen management. R3's provider order singed August 19, 2022, indicated R3 received two liters of continuous oxygen for hypoxia. R3's EMAR dated December 1, 2022, through December 21, 2022, included continuous oxygen two liters per minute via nasal cannula every shift. On December 20, 2022, at 6:40 a.m., the surveyor observed R3 in bed with oxygen via nasal cannula. R3's treatment plan lacked the following required content for oxygen administration: - resident specific instructions related to the treatments/therapy administration;	01940		

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01940	Continued From page 108 - process for notifying an RN or appropriate licensed health professional when an issue or concern arises; and - resident specific requirements related to documentation of treatments/therapy received, verification that it was administered as prescribed and monitoring to prevent possible complications and/or adverse reactions. On December 22, 2022, at 4:58 p.m., RN-A verified R2 and R3's records were missing required content. RN-A stated the licensee had been using the same format for all resident records and did not realize it was lacking content. RN-A further stated licensee will update all resident records to reflect the requirement. The licensee's Resident Service Plans policy dated April 1, 2019, indicated the individualized treatment/therapy plan was established for residents who require prescribed treatments/therapy services and the plan would include the following: - statement of type of services that will be provided; - resident specific instructions related to the treatments/therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - process for notifying an RN or appropriate licensed health professional when an issue or concern arises; and - resident specific requirements related to documentation of treatments/therapy received, verification that it was administered as prescribed and monitoring to prevent possible complications and/or adverse reactions. No further information was provided	01940		

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01940	Continued From page 109 TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=G	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) 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; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating nursing tasks of prescribed treatment administration, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident, and were able to demonstrate, to the registered nurse (RN), the ability to competently follow the procedure for one of two employees (unlicensed	01950		

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01950	Continued From page 110 personnel (ULP)-C). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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-C was hired on February 27, 2018, under the comprehensive license, and began providing services on August 1, 2021, under the assisted living license. ULP-C's employee record included a competency evaluation titled Skills Competency Medication and Treatment - Blood Glucose Testing dated October 11, 2019, which indicated licensed practical nurse (LPN)-K evaluated ULP-C's competency of blood glucose monitoring. Underneath LPN-K's signature and date on the competency form was an undated ink stamp of RN-A's signature. R2's provider orders dated July 8, 2022, included blood glucose monitoring four times per day and update RN on call if blood sugar is below 70 or above 400. R2's provider orders dated November 23, 2022, included insulins lispro (generic for Humalog KwikPen) 16 units (U) three times daily with meals, and Lantus 12 U at bedtime hold for blood sugars less than 170.	01950		

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01950	Continued From page 111 R2's electronic medication administration record (EMAR) dated December 1, 2022, through December 31, 2022, indicated ULP-C completed blood glucose monitoring for R2 five times in the month of December. In addition, ULP-C administered Humalog KwikPen 16 U two times on December 1, 2022, one time on December 4, 2022, and one time on December 15, 2022. ULP-C held insulin one time on December 15, 2022, based on the blood sugar reading. On December 21, 2022, at 4:14 p.m., RN-B stated the orientation training was completed by a staffing coordinator or LPNs and competencies were completed by the LPNs. On December 21, 2022, at 4:34 p.m., RN-A stated they had LPNs assist with competency training for delegated tasks. RN-A stated competencies were previously completed by a former RN until approximately September 2021, and later, the LPN assisted with competency testing. RN-A stated, "The LPN doesn't usually sign off she does the competency testing, she just does them and then updates the RN when they are done." On December 22, 2022, at 10:16 a.m., ULP-C stated they were trained and "tested out" by LPN-K on colostomy bags, blood glucose, hand washing and "everything" by attending a class led by LPN-K, followed by shadowing, and demonstrating back to LPN-K. The licensee's RN Delegation policy dated August 1, 2019, indicated a RN may delegate nursing services to a ULP that had demonstrated to the RN the ability to competently follow the procedures for the client [resident] and possess the knowledge and the skills consistent with the	01950		

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01950	Continued From page 112 complexity of the task. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed by evaluation supervisor review on December 27, 2022, however noncompliance remains at a scope and severity of G. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatments were performed as ordered for one of three residents (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	01960		

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01960	Continued From page 113	01960		

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:

R3 was admitted to the licensee on March 7, 2022.

R3's service plan signed on August 28, 2022, indicated R3 received assistance with housekeeping, laundry, transfers, bathing, grooming, dressing, meals, activities, medication administration, behavior management, and toileting.

R3's unsigned service plan printed December 21, 2022, indicated R3 received oxygen management.

R3's provider order singed August 19, 2022, indicated R3 received two liters of continuous oxygen for hypoxia.

On December 21, 2022, at 4:07 p.m., the surveyor observed R3 without oxygen and no signs of respiratory distress.

On December 21, 2022, at 4:35 p.m., the surveyor observed RN-B obtain oxygen saturation level of 92 percent on R3.

On December 21, 2022, at 4:55 p.m., the surveyor asked registered nurse (RN)-B to go to memory care unit to observe R3.

On December 21, 2022, at 4:59 p.m., the surveyor and RN-B observed R3 without oxygen.

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01960	Continued From page 114 RN-B stated R3 was supposed to receive two liters of oxygen continuously. On December 21, 2022, from at 5:09 p.m., the surveyor observed R3 oxygen applied by RN-B. On December 21, 2022, at 5:04 p.m., ULP-E stated if someone received oxygen, PointClickCare (a documenting software system) would indicate it. The surveyor inquired how often the ULP reviewed information. ULP-E stated nurses do not make changes often but if a nurse made a change, they would review information at the start of the shift. In addition, ULP-E stated staff bring R3 to the dining room to eat without oxygen and then place resident back on oxygen when staff take R3 back to the room. The surveyor inquired how frequently R3 was brought to the dining room without oxygen. ULP-E stated R3 did not wear oxygen while eating, but if R3 was in a common area, staff would administer the oxygen. On December 21, 2022, at 5:06 p.m., the surveyor observed six portable oxygen tanks in R3's room, and all portable oxygen tanks were empty. RN-B stated they were going to contact hospice to obtain more oxygen and they would bring an oxygen concentrator to the dining room for R3. On December 22, 2022, at 4:58 p.m., RN-B verified R3's oxygen therapy was not completed according to provider orders. RN-B stated R3 refused continuous oxygen and would take it off even though R3's oxygen levels could drop below 90 percent. RN-B further stated the licensee will instruct ULPs to check on R3 every two hours and encourage R3 to wear oxygen continuously.	01960		

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01960	Continued From page 115 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02090 SS=E	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a resident's dignity for dining and toileting cares for two of four residents (R4, R21). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 On December 20, 2022, at 7:35 a.m., the surveyor observed four residents siting in the dining area of the Hummingbird memory care unit.	02090		

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02090	Continued From page 116 On December 20, 2022, at 7:45 a.m., unlicensed personnel (ULP)-E served breakfast to R4 and all the other residents. ULP-E called out R4 to wake up and eat his meal, but R4's meal was not chopped into smaller manageable size. R4 struggled to pick food items with cutlery from his plate a couple of times before he fell back to sleep. On December 20, 2022, at 7:50 a.m., ULP-E started to help feed R4 his meal, ULP-E gave him two bites and handed R4 the cutlery to feed himself. R4 again struggled with his fork to pick up the pancake but could not and fell asleep again. Meanwhile ULP-E started cleaning the tables for the other residents who had finished eating. On December 20, at 8:50 a.m., ULP-E cleared table without helping R4 to finish his meal or encouraging him to eat. On December 20, 2022, at 8:55 a.m., ULP-E stated R4 is mostly sleepy in the mornings and will not eat even when he gets help. ULP-E further stated R4 is more alert and able to eat without help for the other meals. R21 On December 22, 2022, at 8:30 a.m., the surveyor observed R21's clothes soiled with stool, including his hands and face. R21 paced up and down the hallway saying "it is a mess", touching surfaces including tables, medication cart, counters and other residents; however, the surveyor observed no ULP present to immediately assist R21. At 8:45 a.m., ULP-E came from another resident's room and took R21 for a shower. The surveyor did not observe	02090		

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02090	Continued From page 117 ULP-E immediately sanitize the touched surfaces or call another staff member to do so. On December 22, 2022, at 8:50 a.m., ULP-E stated there are three ULPs in the Hummingbird memory care unit every morning helping residents. ULP-E further stated R21 was usually aggressive (kicking, spiting, throwing) when receiving care and will require several reapproaches before cooperating and may not allow to be toileted every two hours as scheduled. On December 22, 2022, at 4:45 p.m., registered nurse (RN)-A stated all memory care residents are on every two-hour toileting schedule and did not understand why a resident could be walking in soiled clothes without help. RN-A also stated the ULPs are trained to handle residents with behaviors and that could not be reason the resident was unattended but were probably busy helping other residents. The licensee's Resident Rights policy dated September 1, 2019, indicated residents have right guaranteed to them under federal and state laws and regulations, including the right to be treated with dignity and respect. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02090		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and	02110		

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THE WELLSTEAD OF ROGERS	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

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02110	Continued From page 118 procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and designated representatives at the time	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30762	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSTEAD OF ROGERS	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

(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
02110	Continued From page 119 of move in for five of five residents (R1, R2, R3, R4, 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) 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: R1 was admitted to the licensee January 27, 2015, and started receiving assisted living services August 1, 2021. R2 was admitted to the licensee August 1, 2019, and started receiving assisted living services August 1, 2021. R3 was admitted to the licensee for assisted living services on March 7, 2022. R4 was admitted to the licensee November 3, 2020, and started receiving assisted living services August 1, 2021. R5 was admitted to the licensee May 19, 2021, and started receiving assisted living services August 1, 2021. R1, R2, R3, R4, and R5's resident records lacked evidence a resident or representative received the written policies and procedures that addressed 144G.82 Subd. 3. at the time of move-in to the facility. On December 20, 2022, at 12:16 p.m., registered	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30762	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02110	Continued From page 120 nurse (RN)-A stated, "we just learned about the policies needed for dementia." RN-A showed they surveyor an undated form titled Assisted Living with Dementia Care Additional Required policies that listed the required policies. RN-A stated the licensee has not provided the dementia care policies to residents. The licensee's undated Dementia License Policies included the ten required dementia policies and indicated the policies would be provided to the residents and/or resident's designated representative at the time of move-in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R3) with oxygen. 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30762	A. BUILDING: _____ B. WING _____	12/27/2022

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02310	Continued From page 121 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: On December 20, 2022, at 10:38, the surveyor observed five oxygen tanks in a metal holder, one oxygen tank in a portable roller, and one oxygen concentrator in R3's room. The surveyor did not observe an oxygen sign outside of R3's room indicating R3 was on oxygen. On December 22, 2022, at 5:03 p.m., registered nurse (RN)-A verified R3's room did not have a posted oxygen in use signage. RN-A stated it had skipped the licensee's mind to post the sign as they were aware of the requirement. RN-A further stated the sign will be posted immediately and all the unused oxygen tanks kept away from the resident room. The licensee's Oxygen Concentrator policy dated September 1, 2019, indicated if a resident was on oxygen, a "No Smoking" sign would be placed outside the resident's room. The licensee's Oxygen Safety General Guideline policy dated September 1, 2019, indicated signs must be posted in prominent places to advise resident and visitors of oxygen hazards and signs must be readable from a distance of five feet, be in plain view at all times of oxygen administration sites. No further information was provided.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 122 TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *12/21/22*
Time: 15:00:00
Report: 8087221282

Food and Beverage Establishment Inspection Report

Location:
The Wellstead Of Rogers
20600 South Diamond Lake Road
Rogers, MN55374
Hennepin County, 27

Establishment Info:
ID #: 0039404
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634281981
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.

2-100 Supervision

2-102.12AMN

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

THERE IS NO FULL TIME STATE CERTIFIED FOOD PROTECTION MANAGER AT THE ESTABLISHMENT. HIRE A FULL TIME EMPLOYEE OR TRAIN AN EXISTING FULL TIME EMPLOYEE AND APPLY FOR THE STATE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE.

Comply By: 03/01/23

Surface and Equipment Sanitizers

Wash Temperature Gauge: = -- at 158 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temperature Gauge: = -- at 191 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 179 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding: GROUND BEEF
Temperature: 161 Degrees Fahrenheit - Location: HOT BOX
Violation Issued: No

Process/Item: Hot Holding: VEGGIES
Temperature: 163 Degrees Fahrenheit - Location: HOT BOX
Violation Issued: No

Process/Item: Ambient Air
Temperature: 3 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: RICE
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO NURSE EVALUATOR II BENARD NYANGENA.

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 8087221282 of 12/21/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
LONNIE PEARSON
KITCHEN MANAGER

Signed:_____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us