DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 24, 2024

Licensee
Central Minnesota Senior Care
2323 Gorton Avenue Southwest
Willmar, MN 56201

RE: Project Number(s) SL20166015

Dear Licensee:

On April 5, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 9, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20166	A. BUILDING: _____ B. WING _____	R 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	2323 GORTON AVENUE SW WILLMAR, MN 56201

(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: SL20166015-1 On April 05, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 10, 2024. At the time of the survey, there were 08 residents; 08 receiving services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}		
{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: (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 actions required	{0 480}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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{0 510}	Continued From page 1	{0 510}		
{0 510} SS=E	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: No further actions required	{0 510}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The 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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	{01640}		

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{01640}	Continued From page 2 (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: No further actions required	{01640}		
{01760} SS=E	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. This MN Requirement is not met as evidenced by: No further actions required	{01760}		
{01950} SS=D	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	{01950}		

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{01950}	Continued From page 3 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 This MN Requirement is not met as evidenced by: No further actions required	{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: No further actions required	{01960}		

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February 2, 2024

Licensee
Central Minnesota Senior Care
2323 Gorton Avenue Southwest
Willmar, MN 56201

RE: Project Number(s) SL20166015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 9, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

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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: SL20166015 On January 8, 2024, through January 10, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were eight residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=E	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	0 510		

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0 510	Continued From page 2 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 that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during AM cares and catheter care by two of two unlicensed personnel (ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2's Service Plan (Waiver) dated January 9, 2024, indicated R2 received services for medication administration, morning cares, evening cares, bathing assist, catheter care, compression socks, heel protectors, mobility, laundry, and housekeeping. On January 9, 2024, at 8:15 a.m. ULP-E and ULP-F were observed assisting R2 with morning cares; this included applying compression	0 510		

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0 510	Continued From page 3 stockings, dressing assist, and performing catheter care. ULP-E and ULP-F were observed to be wearing gloves when the surveyor entered the room. While in standing position on the sit-to-stand lift, ULP-F removed R2's brief, performed peri-care and lowered R2 to a commode. ULP-F removed their gloves, cleansed their hands and exited the room. ULP-E removed their gloves and did not cleanse their hands. Without wearing gloves, ULP-E assisted R2 with removing her pajama pants and bowel got on their hands. ULP-E immediately left the room and washed their hands. After ULP-E entered R2's room, ULP-E donned gloves and changed R2 from a large urinary drainage bag to a leg bag. ULP-E changed their gloves but did not cleanse their hands before reapplying gloves. ULP-F entered the room, cleansed their hands and donned gloves. ULP-F assisted R2 with dressing. ULP-E and ULP-F transferred R2 to a motorized wheelchair via a sit-to-stand lift. ULP-E removed their gloves but did not cleanse their hands after removing the gloves. ULP-F made R2's bed, removed gloves, and cleansed hands at exit. On January 9, 2024, at 9:32 a.m. the surveyor asked ULP-E when they would wash their hands. ULP-E stated, "When I'm all done". ULP-E then stated they should have cleansed their hands "in between," but didn't. On January 9, 2024, at 10:45 a.m. clinical nurse supervisor (CNS)-B stated the expectation with glove removal would be to cleanse hands after removing gloves and prior to applying clean gloves. The licensee's Infection Control Practices policy, undated, indicated that disposable gloves should	0 510		

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0 510	Continued From page 4 be used whenever staff may be handling body fluids. Wash hands, apply clean gloves, dispose in waste receptacle and wash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

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0 810	Continued From page 5 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 develop a fire safety and evacuation plan with required elements and failed to conduct required 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: On January 10, 2024, at 2:30 p.m., licensed assisted living director (LALD)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the FSEP did not include emergency exits on the emergency evacuation plan map. DRILLS Record review of the available documentation	0 810		

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0 810	Continued From page 6 indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. During interview on January 10, 2024, at 2:30 p.m., LALD-A verified the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The 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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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.	01640		

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01640	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident to document agreement on the services to be provided 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's Service Plan (waiver) dated December 20, 2023, lacked a signature or other authentication by the resident documenting agreement on the services to be provided. On January 9, 2024, at 8:20 a.m. unlicensed personnel (ULP)-E was observed to apply compression leg wraps to R3. On January 10, 2024, at 11:10 a.m. licensed assisted living director (LALD)-A stated the service plan had been developed on December 20, 2023, and stated it lacked a signature by the resident as required. The licensee's Conducting Initial and Ongoing Client/Resident Evaluations and Assessments of Resident Needs (including assessments by a registered nurse or appropriate licensed health	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20166	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	2323 GORTON AVENUE SW WILLMAR, MN 56201

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01640	Continued From page 8 professional) and How Changes in a Client's/Resident's Condition are Identified, Managed, and Communicated to staff and other Health Care Providers as Appropriate undated indicated the service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01760 SS=E	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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure as needed (PRN) medications had documentation of effectiveness after administration for three of three residents	01760		

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01760	Continued From page 9 (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's Individual Medication Management Plan dated December 9, 2023, and Service Plan dated January 9, 2024, indicated R2 received medication management services daily. R2's prescriber order dated January 3, 2024, included: -ibuprofen two 200 milligrams (mg) tablets by mouth every six hours PRN for fever. R2's medication administration records (MAR) from January 1, 2024, to January 9, 2024, indicated the following: -ibuprofen two 200 mg tablets by mouth every six hours daily PRN was administered three times and lacked documentation of effectiveness. R3 R3's Individual Medication Management Plan and Service Plan both dated December 20, 2023, indicated R3 received medication management services daily. R3's prescriber order dated March 9, 2023,	01760		

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01760	Continued From page 10 included: -acetaminophen/Tylenol two 500 mg tablets by mouth every six hours PRN for fever, pain, headache, dental pain or menstrual cramps. R3's MAR from January 1, 2024, to January 9, 2024, indicated the following: -acetaminophen/Tylenol two 500 mg tablets by mouth every six hours PRN was administered two times; one of the two administrations lacked documentation of effectiveness. R4 R4's Individual Medication Management Plan dated November 2, 2023, and Service Plan dated September 20, 2023, indicated R4 received medication management services daily. R4's prescriber order dated November 8, 2023, included: -ibuprofen two 200 mg tablets by mouth every six hours as needed for fever. R4's MAR from January 1, 2024, to January 9, 2024, indicated the following: -ibuprofen two 200 mg tablets by mouth every six hours daily as needed was administered once and lacked documentation of effectiveness. On January 9, 2024, at 10:45 a.m. clinical nurse supervisor (CNS)-B stated all PRN medications should have documentation of effectiveness for every dose administered and stated R2, R3, and R4's January 2024, PRN log did not included effectiveness when given as stated above The licensee's Medication Management policy, undated, lacked a process for PRN medication. No further information was provided.	01760		

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01760	Continued From page 11 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01950 SS=D	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 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-E) demonstrated competency in a treatment to a registered nurse (RN). 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	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 12 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on July 14, 2022, to provide direct care services to residents. R3's Service Plan (Waiver) dated December 20, 2023, indicated R3 received assist with compression stockings. On January 9, 2024, at 9:20 a.m. ULP-E was observed to apply Juxa-Lite compression wraps to bilateral lower extremities. ULP-E applied the compression wraps incorrectly numerous times during application while conferring to a diagram provided that morning by the program coordinator. R3 instructed ULP-E through the process to correctly apply compression wraps. ULP-E's employee record lacked a competency for Juxa-Lite compression wrap by the RN. On January 9, 2024, at 9:28 a.m. ULP-E stated he had not been competency tested for Juxa-Lite compression wrap application by the RN. ULP-E stated "I was shown quick by another ULP." ULP-E also stated "I don't usually work here, I work in another house. I love my job." On January 9, 2024, at 10:45 a.m. clinical nurse supervisor (CNS)-B stated ULP-E attend the training by the medical supplier for Juxa-Lite compression wraps on November 15, 2023, but did not document a competency test in the employee's file after the training.	01950		

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01950	Continued From page 13 The licensee's Treatment and Therapy Management policy, undated, indicated when administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the home care provider/facility must ensure that the registered nurse or authorized licensed health professional has instructed the unlicensed personnel in the proper methods with respect to each client/resident and the unlicensed personnel has demonstrated the ability to competently follow the procedure. No further information was provided. 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 facility failed to ensure documentation that treatments were completed as instructed for one of two residents (R3) with weights.	01960		

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01960	Continued From page 14 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's diagnoses included hypertension and diabetes. R3's Treatment and Therapy Plan dated July 10, 2023, and Service Plan dated December 20, 2023, indicated R3 was to be weighed three times a week. R3's record included written prescriber orders dated March 9, 2023, to obtain a weight three times a week. R3's record lacked documentation to indicate weight was obtained as identified on the resident's treatment plan and service plan. R3's "Vital Signs Record" for December 1, 2023, through January 9, 2024, indicated R3's weight was documented December 8, 13, 18, 26, 2023, and January 7, 2024. On January 10, 2024, at 11:14 a.m. licensed assisted living director (LALD)-A stated R3's record should have documentation obtaining weight three times a week and stated this was lacking in R3's record as indicated above.	01960		

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01960	Continued From page 15 The licensee's Treatment and Therapy Management policy, undated, indicated each treatment or therapy administered by an assisted living facility must be documented in the resident's 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/08/24*
Time: 11:41:41
Report: 7930241003

Food and Beverage Establishment Inspection Report

Location:
Central Minnesota Senior Care
2323 Gorton Avenue Sw
Willmar, MN56201
Kandiyohi County, 34

Establishment Info:
ID #: 0039155
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202310513
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS WERE STORED ABOVE MILK AND FRUIT IN THE UPSTAIRS REFRIGERATOR AND RAW BEEF WAS STORED NEXT TO GRAPES IN THE DOWNSTAIRS REFRIGERATOR. STORE ALL RAW FOODS ON THE BOTTOM SHELF OR BOTTOM DRAWER AND ALL READY TO EAT FOODS ABOVE THEM.

Comply By: 01/08/24

4-600 Cleaning Equipment and Utensils

4-601.11C

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

CLEAN THE DOWNSTAIRS FRIDGE/FREEZER ON THE BOTTOM AREA UNDER THE FREEZER DRAWER TO REMOVE BUILD UP.

Comply By: 01/12/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE--UPSTAIRS KITCHEN
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *01/08/24*
Time: 11:41:41
Report: 7930241003
Central Minnesota Senior Care

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: MILK--UPSTAIRS KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 31 Degrees Fahrenheit - Location: MILK--DOWNSTAIRS KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK--UPRIGHT COOLER--NURSE AREA
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7930241003 of 01/08/24.

Certified Food Protection Manager: Elizabeth Hillstrom

Certification Number: 72710 Expires: 09/07/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us