DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 9, 2024

Licensee
Getty Street Assisted Living
1214 Getty Street South
Sauk Centre, MN 56378

RE: Project Number(s) SL30493015

Dear Licensee:

On June 17, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 3, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 3, 2024 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 3, 2024, found not corrected at the time of the June 17, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (b) - $500.00
0650-Employee Records-144g.42 Subd. 8
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - $500.00
1700-Provision Of Medication Management Services-144g.71 Subd. 2 - $500.00

The details of the violations noted at the time of this follow-up survey completed on June 17, 2024 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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.

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 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.

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

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30493	A. BUILDING: _____ B. WING _____	R 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GETTY STREET ASSISTED LIVING	1214 GETTY STREET SOUTH SAUK CENTRE, MN 56378

(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: SL30493015-1 On June 17, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 3, 2024. At the time of follow-up survey, there were 19 residents receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	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 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 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 evaluators ' 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 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (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 action required.	{0 480}		
{0 630} SS=F	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 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 the required content and statement of specific interventions for one of one resident (R1). 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	{0 630}		

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{0 630}	Continued From page 2 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's diagnoses included right humorous fracture (upper broken arm), hypothyroidism (under active thyroid), and hyperlipidemia (high cholesterol). R1's service plan dated April 19, 2024, indicated the resident received services which included medication management, assistance with compression hose, vitals, housekeeping, and laundry. R1's IAPP dated April 2, 2024, indicated the following: - self-preservation - no known concerns; and - behavioral (towards others) - no known concerns. R1's IAPP lacked a review of the resident's susceptibility to be abused by other individuals, including other vulnerable adults and statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On June 17, 2024, at 1:12 p.m., clinical nurse supervisor (CNS)-B stated R1's IAPP was not completed. CNS-B stated R1 was on her to do list, along with other residents as she received new assessments the end of May. The licensee's Individual Abuse Prevention Policy dated August 26, 2022, indicated the individual prevention plans will include individual review or assessment of the residents susceptibility to be abused by another individual, including other	{0 630}		

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{0 630}	Continued From page 3 vulnerable adults, the residents risk of abusing other vulnerable adults, specific measures to minimize the risk of abuse to that person and other vulnerable adults, and measure to minimize the risk of self-abuse, if applicable. No further information was provided.	{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 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 interview and record review, the licensee failed to ensure an employee record	{0 650}		

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{0 650}	Continued From page 4 included documentation of training and competency for one of one unlicensed personnel (ULP-E) providing direct care services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 March 22, 2023, to provide direct care services to residents of the assisted living facility. ULP-E's employee record lacked documentation of registered nurse RN training and competency specific to R2's wound care to lower left leg. On June 17, 2024, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated these competencies are not yet complete. CNS-B stated a meeting is planned for Thursday of this week to complete the competencies for R2's wound care for all staff. The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration policy dated August 26, 2022, indicated the RN will document the training and competency of ULP to competently administer each type of service they are assigned in the staff person's personnel record. The Delegation of Nursing Tasks policy dated	{0 650}		

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{0 650}	Continued From page 5 August 26, 2022, indicated the RN will verify the ULP is trained and competent and is instructed in the proper methods to perform the task with respect to the specific resident; if the ULP is not trained, the RN will provide training in-person, verbally, or through other acceptable methods. The RN or other appropriately licensed staff will document any ULP training and or competencies. No further information was provided.	{0 650}		
{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	{0 810}		

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{0 810}	Continued From page 6 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services;	{01650}		

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{01650}	Continued From page 7 (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 service plans included the required content for three of three residents (R1, R2, 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, 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:	{01650}		

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{01650}	Continued From page 8 R1 R1's diagnoses included right humorous fracture (upper broken arm), hypothyroidism (under active thyroid), and hyperlipidemia (high cholesterol). R1's service plan dated May 1, 2024, indicated R1 received medication administration, vitals, housekeeping, and laundry. R2 R2's diagnoses included diabetes, hyperlipidemia, and hypertension (high blood pressure). R2's service plan dated April 24, 2024, indicated R2 received medication administration, wound care, vitals, ambulating, bathing, housekeeping, and laundry. R7 R7's diagnoses included diabetes, hypothyroidism (underactive thyroid), and thrombocytopenia (low platelets in the blood). R7's service plan dated April 29, 2024, indicated R7 received medication management, assistance with compression stockings, vitals, bathing, housekeeping and laundry. R1, R2, and R7's service plans lacked the following content: -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; and -the schedule and methods of monitoring staff providing services. On June 17, 2024, at 1:10 p.m., clinical nurse	{01650}		

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{01650}	Continued From page 9 supervisor (CNS)-B stated she had created an additional page for the service plan with the required content but has not completed with the residents yet. The licensee's Contents of Service Plan policy dated May 24, 2024, indicated the service plan will include: -a description of the services provided; -fees for services; -frequency of each service according to resident assessment and preferences; -schedule and methods of monitoring assessments; -schedule and methods of monitoring staff and providing services; -a contingency plan that includes: action taken if the scheduled service cannot be provided, information and method to contact the facility, names and contact information of persons the resident wishes to have notified in an emergency, names and contact information the residents wishes to have notified if there is a significant adverse change in the resident's condition, identification of and information on who has authority to sign for the resident in an emergency, circumstances in which emergency medical services are not to be summoned, and the service plan and revisions will be entered into the resident record. No further information was provided.	{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	{01700}		

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{01700}	Continued From page 10 a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for three of three residents (R1, R2, 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, 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	{01700}		

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{01700}	Continued From page 11 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included right humorous fracture (upper broken arm), hypothyroidism (under active thyroid), and hyperlipidemia (high cholesterol). R1's Medication/Treatment/Therapy plan dated January 31, 2024, indicated R1 received medication administration. R1's service plan dated May 1, 2024, indicated R1 received medication administration by staff. R1's change in condition assessment dated March 8, 2024, included a medication administration assessment that included: -needs assistance with administering medications; and -using psychotropic medications related to behaviors (see electronic medication administration record (EMAR) for medications). R1's prescriber orders dated February 2, 2024, included the following medications: two for irregular heartbeat, one for high blood pressure, one for cholesterol, two for anxiety, ten supplements, one for restless leg, one for tremor, two for pain, one for nasal congestion, one for sleep, two for heart failure, three for asthma, two for skin condition, two for low potassium, one for weak bones, one for fluid retention, and several as needed medications for shortness of breath, cough, bee allergy, skin conditions, asthma, constipation, dry eye, pain, gastric upset and loose stool.	{01700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30493	A. BUILDING: _____ B. WING _____	R 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GETTY STREET ASSISTED LIVING	1214 GETTY STREET SOUTH SAUK CENTRE, MN 56378

(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
{01700}	Continued From page 12 R2 R2's diagnoses included diabetes (low blood sugar), hyperlipidemia, and hypertension (high blood pressure). R2's Medication/Treatment/Therapy Plan dated May 9, 2022, indicated R2 received medication administration. R2's service plan dated January 23, 2024, indicated R2 received medication administration by staff. R2's 90-day Assessment dated January 23, 2024 included a medication administration assessment that included: -needs assistance administering medications; and -using psychotropic medications related to behaviors (see EMAR for medications). R2's Individualized Medication Management Plan dated April 16, 2021, indicated R2 received medication administration. R2's prescriber orders dated December 8, 2023, included the following medications: three supplements, one for cholesterol, two for shortness of breath, one for dry nose, one for low potassium, one for iron deficiency, two for diabetes, one for sleep, one for fluid retention, one for high blood pressure, two for constipation, one for urinary, one for heart failure, one for pain, one for gastric upset, two insulin's, one for irregular heartbeat, and several as needed medications for skin, shortness of breath, dry eyes, constipation, and pain. R7 R7's diagnoses included diabetes,	{01700}		

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	30493	A. BUILDING: _____ B. WING _____	R 06/17/2024

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{01700}	Continued From page 13 hypothyroidism (underactive thyroid), and thrombocytopenia (low platelets in the blood). R7's Medication/Treatment/Therapy Plan dated April 26, 2024, indicated R7 received medication administration. R7's service plan dated April 29, 2024, indicated R7 received medication management, assistance with compression stockings, vitals, bathing, housekeeping and laundry. R7's return from hospital Assessment dated April 26, 2024 included a medication administration assessment that included: -needs assistance administering medications, is able to self-administer neb treatment after nursing set up; and -using psychotropic medications related to behaviors (see EMAR for medications). R7's EMAR dated June 1, 2024 through June 30, 2024 included the following medications: one for fluid retention, one for anxiety, one for high cholesterol, one for hypothyroidism, two for acid reflux, three for constipation, two for diabetes, one for urinary retention, four for supplement, one for high blood pressure, one for flatulence, one for muscle cramps, two for psoriasis, one for mood, one for pain, one for sleep, two insulins for diabetes, and several as needed medications for constipation, pain, loose stools, anaphylaxis allergic reactions, and skin conditions. R1, R2, and R7's record lacked evidence the RN conducted a face-to-face assessment to include a review of all medications the resident was known to be taking to include, side effects, contraindications, allergic or adverse reactions and actions to address these issues.	{01700}		

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{01700}	Continued From page 14 On June 17, 2024, at 1:07 p.m., clinical nurse supervisor (CNS)-B stated new medication management assessments with the required content was received the end of May but has not completed the assessments yet. The licensee's Medication Assessment policy dated May 29, 2024 indicated a medication management assessment will include, identification of all known medications, supplements, and herbal remedies the resident is currently taking, review medications side effects, contraindications, allergic or adverse reactions, interventions to prevent medication diversion, and provide instructions to the resident and any legal or designated representatives on interventions to prevent diversion of medications. No further information was provided.	{01700}		

Electronically Delivered

April 25, 2024

Licensee
Getty Street Assisted Living
1214 Getty Street South
Sauk Centre, MN 56378

RE: Project Number(s) SL30493015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 3, 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 . . ."

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 may be 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.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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 survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services S-S = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30493	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: SL30493015 On April 1, 2024, through April 3, 2023 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 25 receiving services under the Assisted Living license. An immediate correction order was identified on April 3, 2024, issued for SL30493015, tag identification 2310. On April 3, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of H.	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 April 1, 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		
0 630 SS=F	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 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;	0 630		

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0 630	Continued From page 2 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 observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content and statement of specific interventions for two of two residents (R1, R4) and lacked an updated IAPP for R1 for change in independence. 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 potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included right humorous fracture (upper broken arm), hypothyroidism (under active thyroid), and hyperlipidemia (high cholesterol). R1's service plan dated March 8, 2024, indicated the resident received services which included medication management, assistance with compression hose, vitals, housekeeping, and laundry. On April 2, 2024, at 7:40 a.m., surveyor observed unlicensed personnel (ULP)-E administer R1's	0 630		

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0 630	Continued From page 3 scheduled morning medications. R1's IAPP dated January 31, 2024, indicated the following: -ambulates with a supportive device, hemi-walker (a walker that is intended for use by individuals who have weakness or loss of function on one side of the body); -needs some supervision/assistance with toileting, personal hygiene/grooming and dressing; -takes medications, has vision, hearing and or/other sensory impairments, health concerns, and allergies; and -no concerns with eating/drinking, speech/communication, finances, human sexuality, self-preservation, behavioral or community orientation. R1's change in condition assessment dated March 8, 2024, indicated the following: -shows no signs of wandering/elopement risk; -displays no signs of self-abuse behaviors; -exhibits no choking episodes or need of supervision; -displays no signs of suicidal behaviors or tendencies; -displays no destructive/abusive behaviors; -resident needs assistance to get through an evacuation of the building in emergency situation, stand by assist with hemi-walker and escorts; -monitor for behaviors/confusion/hallucinations, report any concerns and interventions used to nurse and nurse will determine follow-up plan; -resident displays positive interaction with others independently and without incident; -resident displays no aggressive/combative behaviors; and -resident displays healthy one on one interaction with other residents and staff.	0 630		

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0 630	Continued From page 4 R4 R4's diagnoses included chronic obstructive pulmonary disease (a lung disease that block airflow and make it difficult to breathe), generalized anxiety disorder, and dementia (memory loss). R4's service plan dated September 28, 2023, indicated the resident received services for medication administration, assistance with showering, dressing, grooming, housekeeping, and laundry. On April 2, 2024, at 9:32 a.m., surveyor observed ULP-F administer R4's scheduled morning nebulizer treatment. R4's IAPP dated June 9, 2022, indicated the following: -no concerns with mobility, eating/drinking, toileting, speech/communications, human sexuality, self-preservation, community orientation; -personal hygiene/grooming-needs some supervision/assistance; -dressing-needs some supervision/assistance; -has vision, hearing and or/other sensory impairments, allergies, health concerns, needs some supervision/assistance making and keeping medical appointments, refuses medications/medical treatments; -understands value/concepts of money, but needs some supervision/assistance; and -exhibits verbal aggression towards others, and impaired judgement/actions when anxious/upset. R4's 90 day assessment dated February 8, 2024, indicated the following: -shows no signs of wandering/elopement risk;	0 630		

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0 630	Continued From page 5 -must supervise and monitor at all times to prevent and stop self-abusive behaviors, notify nursing of any abuse behaviors, nursing to update appropriate contact, resident is neglectful of self-care, bathing, and grooming; -exhibits no choking episodes or need for supervision; -displays no suicidal tendencies; -must be supervised to help prevent and alleviate any destructive/abusive behaviors; -resident needs assistance to get through an evacuation of the building aid in emergency situation, verbal cueing is necessary; -monitor for behaviors/confusion/hallucinations, report any concerns and interventions used to nurse, and nurse will determine follow-up plan; -assist with redirecting negative interactions with others, supervise and assist, notify nursing of behaviors nursing to notify provider (psychiatrist, etc) when necessary; -constantly supervise and assist resident in redirecting aggressive/combative behaviors, resident displays verbal aggression towards staff when staff assist with daily cares, showers, and hygiene, resident will yell at staff, call them rude names, swear at them, and even put a fist up in their face at times, especially when he is being resistive to cares and or it is not time yet for his as needed inhaler/nebulizer when he is requesting them, at the end of shift staff are to document any of the behaviors that occurred on their shift, notify appropriate providers if necessary; and -prompt and cue resident to enforce positive relationships, encourage resident to develop one on one relations, update nursing of negative behaviors related to this, nursing to update appropriate providers/contacts. R1 and R4's IAPP lacked a review of the	0 630		

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0 630	Continued From page 6 resident's susceptibility to be abused by other individuals, including other vulnerable adults and statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults, and self-abuse. On April 3, 2024, at 2:30 p.m., clinical nurse supervisor (CNS)-C stated the same assessments are used for all residents, and the IAPP's failed to include a review of the resident's susceptibility to be abused by other individuals, including other vulnerable adults and statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults, and self-abuse. Additionally, she was not aware of the required content in the IAPP and had not yet updated R1's IAPP following a change in the resident's independence. The licensee's undated Resident Assessments policy did not include information on the Individual Abuse Prevention Assessment or Plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;	0 650		

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0 650	Continued From page 7 (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee record included documentation of training and competency for one of one unlicensed personnel (ULP-E) providing direct care services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 the potential to affect a large portion or all of the residents). The findings include: ULP-E was hired on March 22, 2023, to provide direct care services to residents of the assisted living facility.	0 650		

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0 650	Continued From page 8 On April 2, 2024, at 10:37 a.m., surveyor observed ULP-E perform wound care on R2. ULP-E stated the registered nurse (RN) trained staff on R2's wound care. Additionally, ULP-E stated R2 went to the wound clinic every other week, and if there is a change, the RN will retrain staff. ULP-E's employee record lacked documentation of registered nurse RN training and competency specific to R2's wound care to lower left leg. On April 2, 2024, at 1:12 p.m., clinical nurse supervisor (CNS)-B stated ULP-E was trained on specific instructions for R2's wound care, but the training was not documented. Additionally, CNS-B stated general wound training is completed at hire, and ULPs are trained on specific orders for residents when the provider orders are received but was not aware specific resident instructions needed to be documented. The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration policy dated August 26, 2022, indicated the RN will document the training and competency of ULP to competently administer each type of service they are assigned in the staff person's personnel record. The Delegation of Nursing Tasks policy dated August 26, 2022, indicated the RN will verify the ULP is trained and competent and is instructed in the proper methods to perform the task with respect to the specific resident; if the ULP is not trained, the RN will provide training in-person, verbally, or through other acceptable methods. The RN or other appropriately licensed staff will document any ULP training and or competencies.	0 650		

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0 650	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the missing resident policy was reviewed at least quarterly. This had	0 680		

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0 680	Continued From page 10 the potential to affect all residents, staff, and any visitors 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: The licensee's Missing Resident policy dated August 26, 2022, lacked documentation the policy had been reviewed quarterly. On April 3, 2024, licensed assisted living director (LALD)-A stated the missing person plan is not reviewed quarterly and was not aware this needed to be done. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4, effective October 2022, Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 11 (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 facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). Findings include: Fire Doors: On April 02, 2024, at 2:30 p.m., survey staff toured the facility with admin assistant (AA)- C and executive director (LALD)-C. During the facility tour, survey staff observed and verified the following maintenance issues: During the tour, survey staff observed the fire rated door for west garage door stuck open. The	0 800		

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0 800	Continued From page 12 fire rated door for the pantry, laundry and the office doors were propped open as well. Survey staff explained to the AA-C, that these doors shall close and latch under their own power or have magnetic hold opens installed on them, so they close and latch under fire alarm conditions. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (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.	0 810		

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0 810	Continued From page 13 (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 develop a fire safety and evacuation plan with required elements. 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: During an interview on April 02, 2024, at 3:35 p.m., administrative assistant (AA)-C provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the facility fire safety plan did not provide complete actions for employees and residents to take in the event of a fire or similar emergency. This plan also lacked the complete procedures for residents' movement, evacuation,	0 810		

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0 810	Continued From page 14 and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement of evacuation. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. Documentation showed evacuation drills being done on a quarterly basis. AA-C verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (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	01650		

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01650	Continued From page 15 identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans included the required content for three of three residents (R1, R2, 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 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's diagnoses included right humorous fracture (upper broken arm), hypothyroidism (under active thyroid), and hyperlipidemia (high cholesterol). R1's service plan dated March 8, 2024, indicated R2 received medication administration, vitals, housekeeping, and laundry. On April 2, 2024, at 7:40 a.m., surveyor observed unlicensed personnel (ULP)-E administer R1's scheduled morning medications.	01650		

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01650	Continued From page 16 R2 R2's diagnoses included diabetes, hyperlipidemia, and hypertension (high blood pressure). R2's service plan dated January 23, 2024, indicated R2 received medication administration, wound care, vitals, ambulating, bathing, housekeeping, and laundry. On April 2, 2024, at 10:37 a.m., the surveyor observed ULP-E perform cares to R2's lower legs. R4 R4's diagnoses included chronic obstructive pulmonary disease (a lung disease that block airflow and make it difficult to breathe), generalized anxiety disorder, and dementia (memory loss). R4's service plan dated September 28, 2023, indicated the resident received medication administration, vitals, assistance with showering, dressing, grooming, housekeeping, and laundry. On April 2, 2024, at 9:32 a.m., surveyor observed ULP-F administer R4's scheduled morning nebulizer treatment. R1 and R4's service plans lacked the following content: -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; and -the schedule and methods of monitoring staff providing services. R2's service plan lacked the following content:	01650		

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01650	Continued From page 17 -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -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. On April 3, 2024, at 2:41 p.m., clinical nurse supervisor (CNS)-B stated she knew this specific content was missing and had been working on the service plans. The licensee's undated Contents of Service Plan policy indicated the service plan will include: -a description of the services provided; -fees for services; -frequency of each service according to resident assessment and preferences; -schedule and methods of monitoring assessments; -schedule and methods of monitoring staff and providing services; -a contingency plan that includes: action taken if the scheduled service cannot be provided, information and method to contact the facility, names and contact information of persons the resident wishes to have notified in an emergency, names and contact information the residents wishes to have notified if there is a significant adverse change in the resident's condition, identification of and information on who has authority to sign for the resident in an emergency, circumstances in which emergency medical services are not to be summoned, and the	01650		

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01650	Continued From page 18 service plan and revisions will be entered into the resident record. 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 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.	01700		

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01700	Continued From page 19 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 face-to-face medication management assessment to include all required content for three of three residents (R1, R2, 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 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 April 1, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R1 R1's diagnoses included right humorous fracture (upper broken arm), hypothyroidism (under active thyroid), and hyperlipidemia (high cholesterol). R1's Medication/Treatment/Therapy plan dated January 31, 2024, indicated R1 received medication administration. R1's service plan dated March 8, 2024, indicated R1 received medication administration by staff. R1's change in condition assessment dated March 8, 2024, included a medication	01700		

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01700	Continued From page 20 administration assessment that included: -needs assistance with administering medications; and -using psychotropic medications related to behaviors (see electronic medication administration record (EMAR) for medications). R1's prescriber orders dated February 2, 2024, included the following medications: two for irregular heartbeat, one for high blood pressure, one for cholesterol, two for anxiety, ten supplements, one for restless leg, one for tremor, two for pain, one for nasal congestion, one for sleep, two for heart failure, three for asthma, two for skin condition, two for low potassium, one for weak bones, one for fluid retention, and several as needed medications for shortness of breath, cough, bee allergy, skin conditions, asthma, constipation, dry eye, pain, gastric upset and loose stool. On April 2, 2024, at 7:40 a.m., surveyor observed unlicensed personnel (ULP)-E administer R1's scheduled morning medications. R2 R2's diagnoses included diabetes (low blood sugar), hyperlipidemia, and hypertension (high blood pressure). R2's Medication/Treatment/Therapy Plan dated May 9, 2022, indicated R2 received medication administration. R2's service plan dated January 23, 2024, indicated R2 received medication administration by staff. R2's 90-day Assessment dated January 23, 2024 included a medication administration assessment	01700		

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01700	Continued From page 21 that included: -needs assistance administering medications; and -using psychotropic medications related to behaviors (see EMAR for medications). R2's Individualized Medication Management Plan dated April 16, 2021, indicated R2 received medication administration. R2's prescriber orders dated December 8, 2023, included the following medications: three supplements, one for cholesterol, two for shortness of breath, one for dry nose, one for low potassium, one for iron deficiency, two for diabetes, one for sleep, one for fluid retention, one for high blood pressure, two for constipation, one for urinary, one for heart failure, one for pain, one for gastric upset, two insulin's, one for irregular heartbeat, and several as needed medications for skin, shortness of breath, dry eyes, constipation, and pain. On April 2, 2024, at 10:37 a.m., the surveyor observed ULP-E perform cares to R2's lower extremities. R4 R4's diagnoses included chronic obstructive pulmonary disease (a lung disease that block airflow and make it difficult to breathe), generalized anxiety disorder, and dementia (memory loss). R4's Medication/Treatment/Therapy Plan dated June 9, 2022, indicated R4 received medication administration. R4's service plan dated September 28, 2023, indicated R4 received medication administration	01700		

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	30493	A. BUILDING: _____ B. WING _____	04/03/2024

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01700	Continued From page 22 from staff. R4's 90-day Assessment dated February 8, 2024, included a medication administration assessment that included: -needs assistance administering medications and supervision while administering his inhalers as resident will refuse to give it back; -using psychotropic medications related to behaviors (see EMAR for medications); and -resident is diabetic, nursing does blood sugar checks and administer medications as indicated. R4's prescriber orders dated December 8, 2023 included the following medications: one for pain, one for urinary hesitancy, two for blood thinner, three for shortness of breath, one supplement, two for depression, two for cholesterol, two for diabetes, one for sleep, one for anxiety, one for heartburn, one for low potassium, and several as needed medications for skin, shortness of breath, pain, loose stool, constipation, heartburn, anxiety, and dry eyes. On April 2, 2024, at 9:32 a.m., surveyor observed ULP-F administer R4's scheduled morning nebulizer treatment. R1, R2, and R4's record lacked evidence the RN conducted a face-to-face assessment to include a review of all medications the resident was known to be taking to include, side effects, contraindications, allergic or adverse reactions and actions to address these issues. Additionally, R2's lacked specific instructions for unopened insulin storage. On April 3, 2024, at 2:59 p.m., clinical nurse supervisor (CNS)-B stated R2 had not had a medication management services assessment	01700		

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01700	Continued From page 23 completed yearly and was missing required content as noted. CNS-B stated medication management assessments are done face to face and was unaware of the required content. The licensee's undated Resident Assessments Policy did not address medication management assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) monitored and reassessed resident medication management services at a minimum annually for two of two residents (R2, 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 widespread scope (when	01710		

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01710	Continued From page 24 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 April 1, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R2 R2's diagnoses included diabetes (low blood sugar) hyperlipidemia (high cholesterol) and hypertension (high blood pressure). R2's Medication/Treatment/Therapy Plan dated May 9, 2022, indicated R2 received medication administration. R2's service plan dated January 23, 2024, indicated R2 received medication administration by staff. R2's 90-day Assessment dated January 23, 2024, included a medication administration assessment that included: -needs assistance administering medications; and -using psychotropic medications related to behaviors (see electronic medication administration record (EMAR) for medications). R2's Individualized Medication Management Plan dated April 16, 2021, indicated R2 received medication administration. R2's prescriber orders dated December 8, 2023, included the following medications: three supplements, one for cholesterol, two for	01710		

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01710	Continued From page 25 shortness of breath, one for dry nose, one for low potassium, one for iron deficiency, two for diabetes, one for sleep, one for fluid retention, one for high blood pressure, two for constipation, one for urinary, one for heart failure, one for pain, one for gastric upset, two insulins, one for irregular heartbeat, and several as needed medications for skin, shortness of breath, dry eyes, constipation, and pain. On April 2, 2024, at 10:37 a.m., the surveyor observed unlicensed personnel (ULP)- E perform cares on R2's lower extremities. R4 R4's diagnoses included chronic obstructive pulmonary disease (a lung disease that block airflow and make it difficult to breathe), generalized anxiety disorder, and dementia (memory loss). R4's Medication/Treatment/Therapy Plan dated June 9, 2022, indicated R4 received medication administration. R4's service plan dated September 28, 2023, indicated R4 received medication administration by staff. R4's 90-day Assessment dated February 8, 2024, included a medication administration assessment that included: -needs assistance administering medications and supervision while administering his inhalers as resident will refuse to give it back; -using psychotropic medications related to behaviors (see EMAR for medications); and -resident is diabetic, nursing does blood sugar checks and administer medications as indicated.	01710		

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01710	Continued From page 26 R4's prescriber orders dated December 8, 2023 included the following medications: one for pain, one for urinary hesitancy, two for blood thinner, three for shortness of breath, one supplement, two for depression, two for cholesterol, two for diabetes, one for sleep, one for anxiety, one for heartburn, one for low potassium, and several as needed medications for skin, shortness of breath, pain, loose stool, constipation, heartburn, anxiety, and dry eyes. On April 2, 2024, at 9:32 a.m., surveyor observed ULP-F administer R4's scheduled morning nebulizer treatment. R2 and R4's record lacked evidence the RN conducted medication monitoring and reassessment with the resident and/or their representative as needed or at least annually. On April 3, 2024, at 2:59 p.m., CNS-B stated R2 and R4's monitoring and assessments had not been done annually and was unaware of the annual requirement. The licensee's undated Resident Assessments Policy did not address medication management assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility	01730		

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01730	Continued From page 27 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 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.	01730		

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01730	Continued From page 28 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 plan for each resident to include all required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on April 1, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R1's diagnoses included right humorous fracture (upper broken arm), hypothyroidism (under active thyroid), and hyperlipidemia (high cholesterol). R1's service plan dated March 8, 2024, indicated R2 received medication administration, vitals, housekeeping, and laundry. R1's Medication/Treatment/Therapy plan dated January 31, 2024, indicated R1 received medication administration. R1's change in condition assessment dated March 8, 2024, included a medication administration assessment that included:	01730		

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01730	Continued From page 29 -needs assistance with administering medications; and -using psychotropic medications related to behaviors (see electronic medication administration record (EMAR) for medications). R1's prescriber orders dated February 2, 2024, included the following medications: two for irregular heartbeat, one for high blood pressure, one for cholesterol, two for anxiety, ten supplements, one for restless leg, one for tremor, two for pain, one for nasal congestion, one for sleep, two for heart failure, three for asthma, two for skin condition, two for low potassium, one for weak bones, one for fluid retention, and several as needed medications for shortness of breath, cough, bee allergy, skin conditions, asthma, constipation, dry eye, pain, gastric upset and loose stool. On April 2, 2024, at 7:40 a.m., surveyor observed unlicensed personnel (ULP)-E administer R1's scheduled morning medications. R1's record lacked and Individualized Medication Management Plan to include the following: -a statement describing the medication management services that will be provided; -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse	01730		

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01730	Continued From page 30 or appropriate licensed health professional when a problem arises with medication management services; and -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. On April 3, 2023, at 2:59 p.m., CNS-B stated she did not have an Individualized Medication Management Plan for R1 and has been unable to locate the paper form since she took the CNS position and was aware the form needs to be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and	01930		

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01930	Continued From page 31 communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines. 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 April 1, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services to residents as prescribed. On April 3, 2024, at 3:25 p.m., CNS-B stated she "had not gotten to the treatment and therapy policies since taking over as CNS." The policies and procedures provided did not include treatment and therapy policies to address the following: - requesting and receiving orders or prescriptions for treatments or therapies;	01930		

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01930	Continued From page 32 - providing the treatment or therapy; - educating and communicating with residents about treatments or therapies they are receiving; - monitoring and evaluating the treatment or therapy; and - communicating with the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01930		
01940 SS=E	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	01940		

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01940	Continued From page 33 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 and implement a treatment or therapy management plan to include all required content for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: During the entrance conference on April 1, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment services to residents. R1 R1's diagnoses included right humorous fracture (upper broken arm), hypothyroidism (under active thyroid), and hyperlipidemia (high cholesterol). R1's prescriber orders dated January 17, 2024, included an order for TEDS (thrombo-embolic	01940		

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01940	Continued From page 34 deterrent socks) to reduce BLE (bilateral lower extremities) swelling. R1's task administration record dated March 1, 2024, through March 31, 2024, indicated staff were to apply compression socks on both lower legs daily in the morning and remove each night. Rinse with water and hang to dry overnight in the bathroom. Staff every time you remove a set of socks they must be washed and hung to dry. On April 2, 2024, at 7:40 a.m., surveyor observed unlicensed personnel (ULP)-E administer R1's scheduled morning medications, resident declined compression hose application. R1's service plan dated March 8, 2024, indicated directions: apply compression socks to both lower legs daily in the morning and remove each night. Rinse with water and hang to dry overnight in the bathroom. Staff every time you remove a set of socks they must be washed and hung to dry. R1's service plan dated March 8, 2024, lacked evidence of an individualized treatment or therapy management plan which included the following: -identification of treatment or therapy tasks that will be delegated to ULPs; -procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements related 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. R2	01940		

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GETTY STREET ASSISTED LIVING	1214 GETTY STREET SOUTH SAUK CENTRE, MN 56378

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01940	Continued From page 35 R2's diagnoses included diabetes (low blood sugar), hyperlipidemia, and hypertension (high blood pressure). R2's prescriber orders dated March 19, 2024, included an order for left lower leg ulcers: Cleanse wound with soap and water, rinse and dry completely. Ok to shower, but please do not soak. Apply moisturizer to dry skin. Apply triamcinolone cream to the area of redness and irritation not in the wounds. Cover open area with Cuticerin (impregnated, non-aqueous, non-linting dressing) cut to fit, portion of ABD (abdominal) pad, secure with soft roll gauze. Cotton sock and Comprilan (inelastic/short-stretch wrap) spiraled from toes to knees. Comprilan may be removed at night if they can be reapplied upon awakening and patient lays flat while sleeping. Change dressing daily and as needed. If increased redness, swelling, pain, odor, purulent develops, body aches, fever, chills, nausea/vomiting, patient feeling unwell, patient to seek medical/urgent care/ER (emergency room) if needed. R2's task administration record dated March 1, 2024, through March 31, 2024, indicated for lower extremities itching: ask resident if he has any itching to lower bilateral extremities, if yes, apply triamcinolone cream. Wound care to bilateral lower legs: Cleanse with mild soapy water, rinse and dry completely. Apply moisturizer to dry skin. To lower left leg ulcers: Cover open areas with Cuticerin cut to fit; portion of ABD pad, secure with soft roll of gauze. Change dressing daily and as needed. To bilateral lower legs: apply cotton socks and Comprilan wraps spiraled from the base of the toes to below the knees. Comprilan may be removed at bedtime if they can be reapplied upon waking and patient lays flat while sleeping. If legs become numb, cold, or tingle	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30493	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GETTY STREET ASSISTED LIVING	1214 GETTY STREET SOUTH SAUK CENTRE, MN 56378

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01940	Continued From page 36 then remove wraps and update nurse. Make sure to date and initial dressing. On April 2, 2024, at 10:37 a.m., the surveyor observed ULP-E perform cares to R2's lower extremities. R2's service plan dated January 23, 2024, indicated the following: -Wound care directions: To bilateral lower legs: Cleanse with mild soapy water, rinse and dry completely. Apply moisturizer to dry skin. To lower left leg ulcers: Cover open areas with Cuticerin cut to fit; portion of ABD pad, secure with soft roll of gauze. Change dressing daily and as needed. To bilateral lower legs: apply cotton socks and Comprilan wraps spiraled from the base of the toes to below the knees. Comprilan may be removed at bedtime if they can be reapplied upon waking and patient lays flat while sleeping. If legs become numb, cold, or tingle then remove wraps and update nurse. Make sure to date and initial dressing. Daily at 9:30 a.m., as needed. -ACE wrap directions: To both lower legs-apply cotton sock and Comprilan compression wraps-spiral wrap from toes to knees. Apply in morning and remove at bedtime. Cleanse legs with soapy water, and dry, and apply moisturizer to dry skin before applying sock and wraps. Apply another white sock on top of each wrap on each leg. Daily at 9:00 a.m., 8:00 p.m. -Wound care directions, clean with soap and water, rinse and dry completely. Vaseline or moisturizer may be applied. Cover open areas with Curad oil emulsion dressing (or similar product like Cuticerin) cut slightly larger than open ulcer, piece of an ABD pad and secure with the roll gauze/kerlix. Only apply or change as needed for open or draining skin. Daily and as	01940		

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	30493	A. BUILDING: _____ B. WING _____	04/03/2024

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GETTY STREET ASSISTED LIVING	1214 GETTY STREET SOUTH SAUK CENTRE, MN 56378

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01940	Continued From page 37 Needed. -Wound check-Check for drainage of residents wound on both lower legs. Change wound dressing as needed. -Lower extremities itching-Ask resident if he has any itching to lower bilateral extremities. If yes, apply PRN triamcinolone cream and mark as PRN in charting, If no document appropriately. Daily at 9:00 a.m., 8:00 p.m. R2's service plan dated January 23, 2024, lacked evidence of an individualized treatment or therapy management plan which included the following: - identification of treatment or therapy tasks that will be delegated to ULPs; -procedures for notifying a RN or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements related 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. On April 3, 2024, at 3:25 p.m., CNS-B stated the service plan did not have all required content as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=H	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	02310		

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	30493	A. BUILDING: _____ B. WING _____	04/03/2024

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02310	Continued From page 38 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 two of three residents (R2, R5) who utilized bed rails. 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 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 diagnoses included type 2 diabetes, chronic obstructive pulmonary disease, and hyperlipidemia. On April 2, 2024, at 10:37 a.m., the surveyor observed R2 had bilateral bed rails in the upright position, attached to R2's hospital bed. R2's Care Plan dated January 30, 2024, indicated R2 required assistance with bathing/showering, wound care, medication management, assistance with ambulating, housekeeping, and laundry. The care plan indicated in R2's list of adaptive equipment, a hospital bed with side rails.	02310		

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	30493	A. BUILDING: _____ B. WING _____	04/03/2024

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02310	Continued From page 39 R2's 90-day assessment dated January 23, 2024, did not indicate R2 required the use of a bed rail. R2's record lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones, purpose and intention of the bedrail, discussion of the risks versus benefits of the bedrail with the resident and/or the resident's responsible party, any additional interventions that may be needed to mitigate safety, and further lacked on going assessment for the use of an assisted device as required in the uniform assessment tool. R5 R5's diagnoses included type 2 diabetes, hypertension, and chronic back pain. On April 3, 2024, at 9:32 a.m., the surveyor observed R5 had bilateral bed rails in the upright position, attached to R5's hospital bed. R5's Care Plan dated January 30, 2023, indicated R5 required assistance with bathing/showering, medication management, housekeeping and laundry. The care plan indicated in R5's list of adaptive equipment, a hospital bed with side rails. R5's Bedrail Risk Assessment signed and dated January 29, 2018, indicated R5 had bed rails that were currently be used for positioning or support to provide independence. R5's Side Rails Informed Consent and Release dated January 29, 2018, indicated R5 was informed of risks and benefits of the use of side rails, including entrapment. R5's 90 day assessment dated February 8, 2024,	02310		

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02310	Continued From page 40 did not indicate R5 required the use of a bed rail. R5's record lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones and further lacked on going assessment for the use of an assisted device as required in the uniform assessment tool. On April 02, 2024, at 2:08 p.m., clinical nurse supervisor (CNS)-B stated she was unable to find R2's bedrail assessment. Staff were looking in locked file cabinets in the garage; she stated she completed the bed rail assessments when she started because they were not completed by the past registered nurse (RN). Additionally, she stated a past worker who left was supposed to be filing, and was not, as they found drawers of papers not filed and continue to find documents misplaced. On April 03, 2024, at 9:17 a.m., CNS-B stated the bed rail assessments could not be found for R2 and R5. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated February 20, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint."	02310		

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02310	Continued From page 41 Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Installation and use according to manufacturer's guidelines - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by evaluation supervisor review on April 3, 2024, however noncompliance remains at a scope and level of three, pattern (H).	02310		

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud
320-223-7300

Type: Full
Date: *04/01/24*
Time: 11:10:59
Report: 1041241082

Food and Beverage Establishment Inspection Report

Location:
Getty Street Assisted Living
1214 Getty Street South
Sauk Centre, MN56378
Stearns County, 73

Establishment Info:
ID #: 0037532
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3203514333
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.

5-200B Plumbing: cross connections

5-203.14E ***** Priority 1 *****

MN Rule 4626.1085A Mount the spray arm so it cannot hang below the spill rim of a sink or provide an approved backflow prevention device on the faucet.

THE SPRAY ARM IS HANGING BELOW THE SPILL RIM OF THE SINK. REPLACE THE SPRING ON THE SPRAY ARM.

Comply By: 04/01/24

4-200 Equipment Design and Construction

4-204.115 ***** Priority 2 *****

MN Rule 4626.0635 Provide a temperature measuring device in the warewashing machine that indicates the temperature of the water in the wash tank, rinse tank, and the water that enters the sanitizing final rinse manifold or the chemical sanitizing solution tank.

PROVIDE A WATERPROOF THERMOMETER TO MEASURE THE TEMPERATURE OF THE WATER IN THE DISHWASHER.

Comply By: 04/15/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THERE IS A TORN GASKET ON THE UPRIGHT FREEZER IN THE DRY STORAGE ROOM. REPLACE GASKET.

Comply By: 05/31/24

Type: Full
Date: *04/01/24*
Time: 11:10:59
Report: 1041241082
Getty Street Assisted Living

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Hot Water: = at 163 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: SPLIT PEA SOUP- 2 DOOR UNIT
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK-DRY STORAGE ROOM
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	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 1041241082 of 04/01/24.

Certified Food Protection Manager RAPHAEL GRACZYK

Certification Number: 93820 Expires: 11/30/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Linda Heinen

Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us