Electronically Delivered

November 30, 2022

Administrator
Bridgewater At Owatonna
125 Park Street East
Owatonna, MN 55060

RE: Project Number(s) SL34946015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 2, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#34946015 On October 31, 2022, through November 2, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 31 residents; 25 receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 1, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
0 730	Continued From page 3 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a complete discharge summary for one of one resident (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) 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: R4's record lacked a complete discharge summary. R4 discharged on September 30, 2022, to a skilled nursing facility. On October 31, 2022, at 3:33 p.m. clinical nurse supervisor (CNS)-B verified R4's discharge	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
0 730	Continued From page 4 summary did not include all the required content for the discharge summary according to their policy. In addition, CNS-B indicated the same form was used for three discharges since CNS-B started July 2022. The licensee's Discharge Summary policy dated August 1, 2021, noted a discharge summary would be written at the time of discharge and would include a summary of the resident's stay. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the facility in good repair in regards to resident health and safety in accordance with maintenance and repair program. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 5 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: 1. On 10/31/2022 between 2:15 PM to 4:15 PM, survey staff observed during the walk-through of the structure that following areas exhibited electrical issues: RM 109 - usage of an extension cord; Activities Desk - usage of an extension cord; Chapel Area - use of an extension cord that was connected to a power-strip; Hair Salon - the use of a 2-to-6 multi-tap adapter; RM 110 - the use of a 1-to-3 multi-tap adapter. 2. On 10/31/2022 between 2:15 PM to 4:15 PM, survey staff observed during the walk-through of the structure that following areas exhibited sprinkler system issues: Housekeeping - sprinkler heads appeared to be oxidized; Room's 116 and 200 - exhibited high storage of items to close to the sprinkler head; Ceiling tiles were foundto be missing outside of the Boiler Room as-well-as the N Furnace room 3. On 10/31/2022 between 2:15 PM to 4:15 PM, survey staff observed during the walk-through of the structure that two of the emergency lighting units in the N corridor did not illuminate upon testing 4. On 10/31/2022 between 2:15 PM to 4:15 PM, survey staff observed during the walk-through of the structure that in the Mechanical Room and the Electrical Room that there was storage of combustible items	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 6 5. On 10/31/2022 between 2:15 PM to 4:15 PM, survey staff observed during the walk-through of the structure that SW Exit from the facility was egress obstructed by a table and chair 6. On 10/31/2022 between 2:15 PM to 4:15 PM, survey staff observed during the walk-through of the structure that SW Fire Door Assembly did not self-close and latch upon testing (DM)-D verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01290	Continued From page 7	01290		

submitted and received in affiliation with the assisted living license for three of three unlicensed personnel (ULP-F, ULP-H, ULP-I).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

ULP-F
ULP-F was hired on July 1, 2020, and started providing direct care and services to the licensee's residents under the assisted living license on August 1, 2021.

ULP-F's employee record contained a background study dated July 10, 2020, for the previous comprehensive license, at the same location, operated by the licensee's owner. ULP-F's employee record lacked evidence the licensee affiliated a background study for their current assisted living facility license.

ULP-H
ULP-H was hired on August 13, 2020, and started providing direct care and services to the licensee's residents under the assisted living license on August 1, 2021.

ULP-H's employee record contained a background study dated August 7, 2020, for the previous comprehensive license, at the same

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01290	Continued From page 8	01290		

location, operated by the licensee's owner. ULP-F's employee record lacked evidence the licensee affiliated a background study for their current assisted living facility license.

ULP-I
ULP-I was hired on March 29, 2021, and started providing direct care and services to the licensee's residents under the assisted living license on August 1, 2021.

ULP-I's employee record contained a background study dated April 16, 2021, for the previous comprehensive license, at the same location, operated by the licensee's owner. ULP-I's employee record lacked evidence the licensee affiliated a background study for their current assisted living facility license.

On November 11, 2022, at 1:54 p.m. human resources generalist (HRG)-J verified the licensee did not affiliated the background studies for ULP-F, ULP-H, and ULP-I with the licensee's current assisted living facility license.

The licensee's Screening of Home Care Job Applicants policy dated April 1, 2019, indicated after review of the application, verification of any required professional license, registration or certification, and review of the OIG (Office of Inspector General) exclusion list, housing manager and/or nurse may invite the applicant for an interview. At the conclusion of the interview, if it appears that the applicant will meet our agency's requirements and standard, the housing manager and/or nurse will ask the applicant for consent to initiate a background check. Once the applicant's references have been checked and the background check has been completed and the applicant is not disqualified, the housing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01290	Continued From page 9 manger and/or nurse may extend an offer of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 10 (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with all the 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: On November 2, 2022, at 8:21 a.m. unlicensed personnel (ULP)-E was observed to administer oral medications to R1. R1's service plan dated February 2, 2022, indicated medication administration was assigned	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 11 to ULP. R1's Medication Management plan dated July 29, 2022, lacked identification of all medication management tasks that may be delegated to unlicensed personnel. On November 2, 2022, at 3:23 p.m. clinical nurse supervisor (CNS)-B confirmed R1's medication management plan lacked the content listed above, and further stated it was her first one completed and will keep in mind for the next one. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by unlicensed	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01750	Continued From page 12	01750		

personnel (ULP) for three of five residents (R3, R2, R6) observed during medication administration.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R3
R3's diagnoses included type 2 diabetes.

R3's Service Plan dated December 15, 2020, indicated medication administration was assigned to unlicensed personnel (ULP).

R3's physician orders dated July 20, 2022, included: atorvastatin 80 mg (milligrams) by mouth daily (treat high cholesterol), divalproex 125 mg - eight tablets by mouth twice daily (to prevent seizures), fenfibrate 48 mg by mouth daily (treat high cholesterol), insulin lispro kwikpen (fast acting insulin) inject five units subcutaneous three times daily before meals, jantoven 2.5 mg - take two tablets by mouth Monday, Wednesday and Friday (blood thinner), jantoven 2.5 mg by mouth Tuesday, Thursday, Saturday and Sunday, Lantus Solostar 100 unit/milliliter - inject 25 units under the skin twice a day 12 hours apart, levothyroxine 150 mcg (micrograms) by mouth daily (treat thyroid), omeprazole 40 mg by mouth daily (for acid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01750	Continued From page 13	01750		

reflux), oxybutynin 10 mg by mouth daily at bedtime (for urge incontinence), quetiapine 50 mg by mouth - take two tablets by mouth at bedtime (for depression), tamsulosin 0.4 mg by mouth daily (for urge incontinence) and vitamin 1000 units by mouth daily (vitamin supplement).

On November 1, 2022, at 8:12 a.m. ULP-E was observed setting up R3's 8:00 a.m. medications for administration. ULP-E retrieved insulin Lispro Kwikpen from the medication cart. ULP-E prepped the Kwikpen with a needle, prepped upper right arm with an alcohol pad, ULP-E dialed pen to five units and injected Lispro five units mid right deltoid. When asked about priming the Kwikpen prior to dialing up the dosage, ULP-E stated she never primed the Kwikpen prior to administration. November 2022's medication administration record (MAR) did not include the instruction for the ULP to prime the Kwikpen to two units and waste prior to administration. When asked who trained and competency trained ULP-E, she stated the RN and was to rotate sites of administration.

On November 1, 2022, at 8:20 a.m. clinical nurse supervisor (CNS)-B verified R3's Lispro Kwikpen should have been primed to two units, and wasted prior to administration. In addition, CNS-B stated the priming of two units was updated on the November 2022, MAR. When the surveyor asked CNS-B about the proper administration of the insulin, CNS-B stated it should have been given subcutaneously, not intramuscularly. CNS-B stated she would complete follow-up training with staff on insulin administration and priming of the pens.

R2
R2's diagnoses included hypertension (high blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01750	Continued From page 14	01750		

pressure), diabetes mellitus with diabetic polyneuropathy (a type of nerve damage that can occur if you have diabetes), and iron deficiency anemia (a condition in which blood lacks adequate healthy red blood cells).

R2's Service Plan Agreement dated August 15, 2021, indicated the resident received medication administration services provided by nursing/unlicensed personnel (ULP) four times daily.

R2's physician orders dated October 13, 2022, included: insulin lispro 75/25 (a combination insulin made with 75% of an intermediate-acting insulin and 25% of a fast-acting insulin) Kwikpen, inject 64 units under the skin two times a day (for diabetes), amlodipine (to treat hypertension) 10 mg (milligrams) by mouth daily, aspirin 81 mg by mouth daily, ferrous sulfate (for iron deficiency anemia) 325 mg by mouth twice a day, gabapentin (anticonvulsant used to prevent/control seizures and also treat nerve pain) 600 mg by mouth four times a day, lisinopril (for hypertension) 10 mg by mouth daily, metformin (for diabetes) 1500 mg by mouth daily, metoprolol tartrate (for hypertension) 50 mg by mouth daily, and omeprazole (for heartburn) 40 mg by mouth twice a day before breakfast and dinner. The above medications were ordered to be administered at 8:00 a.m.

On November 1, 2022, at 9:04 a.m. ULP-E was observed setting up R2's 8:00 a.m. medications for administration. ULP-E retrieved an unopened insulin lispro 75/25 Kwikpen from the medication refrigerator for R2. ULP-E used an alcohol wipe to swab the end of the Kwikpen prior to applying the needle. ULP-E was not observed to roll the Kwikpen between her hands or invert the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01750	Continued From page 15	01750		

Kwikpen up and down to mix the insulin suspension. ULP-E then dialed the Kwikpen to 60 units and explained that this was the highest level the pen could be turned too and would need to inject an additional 4 units after administering the 60 units. When asked about priming the Kwikpen prior to dialing up the dosage, ULP-E stated she never primes the Kwikpen for R2 when preparing her insulin.

On November 1, 2022, at 9:58 a.m. registered nurse (RN)-B confirmed R2's insulin lispro 75/25 Kwikpen should have been primed prior to administration and further confirmed the Kwikpen should have been rolled and inverted to mix the suspension prior to administration.

R6
R6's diagnoses included, edema, low back pain, and stiffness in the left shoulder.

R6's Service Plan Agreement dated June 30, 2022, indicated the resident received medication administration services provided by nursing/ULP three times a day.

R6's physician orders dated September 27, 2022, included duloxetine (antidepressant also used for pain control) 30 mg by mouth daily, furosemide (diuretic/water pill) 20 mg by mouth every morning, gabapentin 100 mg by mouth three times a day, Vitamin D3 25 mcg (micrograms) by mouth in the morning. All above medications were ordered to be administered at 8:00 a.m.

On November 1, 2022, at 9:20 a.m. ULP-E was observed setting up R6's 8:00 a.m. medications. Upon entering R6's apartment at approximately 9:24 a.m., R6 asked ULP-E when she could take her next "pain pill". ULP-E stated she would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01750	Continued From page 16 check and let her know as the medication was ordered for every six hours as needed. On November 2, 2022, at 2:48 p.m. clinical nurse supervisor (CNS)-B confirmed if a medication is ordered at 8:00 a.m. the staff can administer up to one hour prior to one hour after 8:00 a.m. (7:00 a.m.- 9:00 a.m.). RN-B confirmed ULP-E was running behind with her morning medication pass yesterday (November 1, 2022), and further stated she assisted ULP-E with the medication pass to help her get caught up. The licensee's Administration of Medication by Unlicensed Personnel revised February 1, 2018, indicated: 2. Medications always need to be administered according to the "6 Rights". a. Right person b. Right medication c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops, etc) f. Right chart/record to document that the medication was taken. The licensee's 2.23 Injections - Subcutaneous competency form indicated: Insulin Pens: 13. Insulin pens are to be stored at room temperature after first use (unless otherwise indicated by manufacturer) 14. Roll the pen gently before use 15. Remove the pen cap and clean with alcohol wipe 16. Connect the needle to the pen 17. Prime the pen per manufacturer instructions (see MAR); to remove any air bubbles that may	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01750	Continued From page 17 be present The Insulin Lispro Mix 75/25 Kwikpen package insert/prescribing information dated February 2020, indicated: Instructions for Use Step 1: Pull the pen cap straight off. Do not remove the pen label. Wipe the rubber seal with an alcohol swab. Do not attach the needle before mixing. Step 2: Gently roll the pen between your hands at least 10 times. Step 3: Move the pen up and down (invert) at least 10 times. Mixing by rolling and inverting the pen is important to make sure you get the right dose. After mixing Insulin Lispro Protamine and Insulin Lispro Injectable Suspension Mix 75/25, inject your dose right away. If you wait to inject your dose, the insulin will need to be mixed again. Step 4: Check the liquid in the pen. Insulin Lispro Protamine and Insulin Lispro Injectable Suspension Mix 75/25 should look white and cloudy after mixing. Do not use if it looks clear or has any lumps or particles in it. Step 5: Select a new needle. Pull off the paper tab from the outer needle shield. Step 6: Push the capped needle straight onto the pen and twist the needle on until it is tight. Step 7: Pull off the outer needle shield. Do not throw it away. Pull off the inner needle shield and throw it away. Step 8: To prime you pen, turn the dose knob to select two units. Step 9: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 10: Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01750	Continued From page 18 see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 8 to 10, no more than 4 times. If you still do not see insulin, change the needle and repeat priming steps 8 to 10. Small air bubbles are normal and will not affect your dose. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of five residents (R6) observed during medication administration. This practice resulted in a level two violation (a	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01760	Continued From page 19	01760		

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:

R6's Service Plan Agreement dated June 30, 2022, identified services included medication administration.

R6's prescriber Progress Note dated August 23, 2022, indicated the resident had whitish right eye discharge noted on exam that was most likely bacterial infection. New orders were prescribed for antibacterial eye drops - polymyxin B-trimethoprim 10,000 unit-one mg/ml (milligram per milliliter) ophthalmic solution; administer one drop into both eyes four times a day starting August 23, 2022.

On November 2, 2022, at 9:20 a.m. ULP-E was observed setting up and administering R6's medications which included polymyxin B-trimethoprim 10,000 unit-one mg/ml (milligram per milliliter) ophthalmic solution; administer one drop into both eyes four times a day.

R6's After Visit Summary from the provider dated September 27, 2022, indicated to STOP taking: polymyxin B-trimethoprim 10,000 unit - one mg/ml ophthalmic solution.

On November 1, 2022, at 10:48 a.m. clinical nurse supervisor (CNS)-B stated R6's eye drops were discontinued on September 27, 2022, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01760	Continued From page 20 further stated she had already filled out a medication error report. The licensee's Administration of Medication by Unlicensed Personnel revised February 1, 2018, indicated: 2. Medications always need to be administered according to the "6 Rights". a. Right person b. Right medication c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops, etc) f. Right chart/record to document that the medication was taken. The licensee's 2.21 eye Drops and Ointment competency form indicated: 1. Check the Medication Administration Record (MAR) for the appropriate order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01890	Continued From page 21 by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly for one of three residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 1, 2022, at 8:52 a.m. unlicensed personnel (ULP)-F prepared an insulin pen for administration to R5. R5's insulin injectable pen prepared by ULP-F lacked labels that provided both the date the medication had been opened and the expiration date. The insulin pen prepared by ULP-F included: - Novolog Flexpen 100 U (units)/ml (milliliter) Manufacturer's instructions for Novolog Flex Pen dated June 21, 2021, indicated the pen should be discarded after 28 days. On November 1, 2022, at 8:58 a.m. ULP-F confirmed the Novolog Flexpen in use did not have the open or the expiration date on the insulin pen. On November 1, 2022, at 9:08 a.m. clinical nurse supervisor (CNS)-B verified there were no open	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01890	Continued From page 22 date on the insulin pen in use and stated all insulin pens should be dated when opened. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		

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

Type: Full
Date: *11/01/22*
Time: 07:54:14
Report: 8044221400

Food and Beverage Establishment Inspection Report

Location:
Bridgewater At Owatonna
125 Park Street East
Owatonna, MN55060
Steele County, 74

Establishment Info:
ID #: 0037458
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074510808
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13A ** Priority 2 **

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

No thermometer or stickers for dishwasher.

Comply By: 11/15/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Bucket
Violation Issued: No

Hot Water: = at 160.9 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 34.0 Degrees Fahrenheit - Location: Upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.9 Degrees Fahrenheit - Location: Chicken in upright
Violation Issued: No

Type: Full
Date: *11/01/22*
Time: 07:54:14
Report: 8044221400
Bridgewater At Owatonna

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 158.6 Degrees Fahrenheit - Location: Eggs
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39.1 Degrees Fahrenheit - Location: Salami in upright 2
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.0 Degrees Fahrenheit - Location: Upright 2
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36.0 Degrees Fahrenheit - Location: Upright 3 *
Violation Issued: No

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

HRD inspection conducted with lead surveyor Wendy Buckholz. Report reviewed on site with Elizabeth.

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 8044221400 of 11/01/22.

Certified Food Protection Manager: Brooke A. Olson

Certification Number: FM74932 Expires: 09/08/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Elizabeth

Signed: _____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us