DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 22, 2022

Administrator
Bridgewater At Mankato
630 Reed Street
Mankato, MN 56001

RE: Project Number(s) SL34568015

Dear Administrator:

On August 8, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the June 5, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

PMB

Electronically Delivered

June 28, 2022

Administrator
Bridgewater At Mankato
630 Reed Street
Mankato, MN 56001

RE: Project Number(s) SL34568015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 3, 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, the following fines are assessed pursuant to this evaluation:

St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:	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

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

REQUESTING A HEARING

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

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

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,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-51751 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34568	A. BUILDING: _____ B. WING _____	06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT MANKATO	630 REED STREET MANKATO, MN 56001

(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#34568015 On May 31, 2022, through June 3, 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 23 residents, all of whom received 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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the	0 250		

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 31, 2022, at approximately 11:13 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the licensee were familiar	0 250		

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0 250	Continued From page 3 with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted	0 250		

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0 250	Continued From page 4 to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable.	0 250		

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0 250	Continued From page 5 Page five was electronically signed by owner (O)-I on May 24, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: -orientation, training, and competency evaluations of staff; -conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; -medication and treatment management; -delegation of tasks by registered nurses or licensed health professionals. As a result of this survey, the following orders were issued 0485, 0550, 0650, 0730, 0780, 0790, 0810, 1620, 1640, 1650, 1730, 1750, 1760, 1820, 1910, 1940, 1950, 1960, 1970, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		

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0 485	Continued From page 6	0 485		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure at least three nutritious meals daily according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines. This had the potential to affect all 23 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive	0 485		

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0 485	Continued From page 7 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 31, 2022, at 12:04 p.m., cook (C)-H served residents in house two scalloped potatoes with ham mixed in the potatoes, a slice of banana bread and milk for the lunch meal. Posted on a blackboard on the dining room wall was a piece of paper which read "scalloped potatoes and ham" and "banana bread." At 12:28 p.m., C-H served residents in house one scalloped potatoes with ham mixed in the potatoes, a slice of banana bread and milk for the lunch meal. The blackboard on the dining room wall had written for breakfast "sausage gravy over biscuit, fruit," lunch "ham, scalloped potatoes, rice krispie [sic] bar" and dinner "smoked sausage pasta skillet, fruit." On May 31, 2022, at 12:07 p.m., certified food protection manager (CFPM)-D stated the licensee had a four-week rotation for menus. Week three menu was observed posted on a bulletin board located on the wall in the main lobby area of house two. At 12:28 p.m., week three menu was observed posted on a bulletin board located on the wall in the main lobby area of house one. On June 1, 2022, at 7:50 a.m., residents in house one were served waffles, sausage patty, red juice, and coffee for the breakfast meal. The blackboard on the dining room wall had written for breakfast "pancakes and sausage," lunch "beef commercial, peas, bar" and dinner "corn dogs, tater tots, mandarin oranges". R4 was served toast and had a jar of peanut butter and a	0 485		

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0 485	Continued From page 8 beverage in her own drink container. The "Week 3 Save Menu" updated April 21, 2022, posted identified the following foods were listed for meals: Monday Breakfast: French toast, fruit Lunch: beef gravy over mashed potatoes, veggies, red/white/blue cookies Dinner: chicken, stuffing, green beans Tuesday Breakfast: sausage gravy over biscuit, fruit Lunch: ham, scalloped potatoes, rice krispie bar Dinner: smoked sausage pasta skillet, fruit Wednesday Breakfast: pancake, sausage Lunch: beef commercial, peas, bar Dinner: corn dogs, tater tots, mandarin oranges Thursday Breakfast: omelet, toast Lunch: tacos, Spanish rice, refried beans, angel food cake bites Dinner: sloppy joes, baked beans, potato chips, fruit Friday Breakfast: oatmeal, toast of choice Lunch: loaded baked potatoes, side salad, fruit Dinner: soup, club sandwich, pudding Saturday Breakfast: waffles, fruit Lunch: spaghetti, side salad, breadstick Dinner: shepard's pie, cheesecake Sunday Breakfast: cinnamon roll, fruit	0 485		

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0 485	Continued From page 9 Lunch: BBQ meatballs, cheesy potatoes, veggies, Jell-O Dinner: orange chicken, fried rice, fortune cookie On June 1, 2022, at 11:09 a.m., CFPM-D stated "I do meals, prep ahead." CFPM-D stated C-H "works two days a week" and "we communicate between the two of us" what fruit would be served if the fruit was not identified on the menu. When asked why waffles were served instead of pancakes as indicated on the menu for breakfast on June 1, 2022, CFPM-D stated "overnights did not get made" (referring to the night shift staff). CFPM-D stated banana bread was served instead of rice krispie bar as the licensee had "bananas to use". CFPM-D stated residents were informed verbally of substitutes before the meal was served. CFPM-D stated milk would count as dairy serving and was served at each meal (three times a day). CFPM-D confirmed beverages were not listed on the menu. CFPM-D stated "alternatives" served for meals were "leftovers or cold meat sandwiches." CFPM-D confirmed meal substitution choices were not listed on the menu. CFPM-D stated residents were involved in menu planning. CFPM-D confirmed the menu did not consistently include the daily recommended dietary allowances to be served for protein, grains, vegetable, fruit and dairy according to the USDA guidelines. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 10 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information related to the grievance procedure, resident advocacy information, and information for reporting suspected maltreatment. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 31, 2022, at 12:07 p.m., observation of posted information in a binder located on the wall in the main lobby area of house two (2) included "Elder Complaint Resolution Process". On May 31, 2022, at 12:28 p.m., observation of	0 550		

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	34568	A. BUILDING: _____ B. WING _____	06/03/2022

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0 550	Continued From page 11 posted information in a binder located on the wall in the main lobby area of house one (1) included "Elder Complaint Resolution Process". The "Elder Complaint Resolution Process" posted in house two and house one lacked to include: -the name, telephone number, and email contact information for the individuals who are responsible for handling grievances; -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and -number and contact information and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On June 1, 2022, at 10:54 a.m., licensed assisted living director (LALD)-A stated "ok, that will be an update. It's in the Bill of Rights". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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	0 650		

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0 650	Continued From page 12 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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained training and competency evaluations for delegated tasks for two of two unlicensed personnel (ULP-F, ULP-G) with records reviewed. 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 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).	0 650		

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0 650	Continued From page 13 The findings include: R1's Medication Administration Record (MAR) dated May 2022 and Service Delivery Record dated May 2022, identified ULP's were signing for the treatment and therapy administration of blood sugar checks monitoring/check four times a day. The MAR further indicated "uses Freestyle Libre [a device used to read blood sugar levels] sensor on arm. If sensor is not usable or reading there are tests strips and lancets with supplies to use with reader." R2's Neurological Flow Sheet dated May 11 and 12, 2022, identified ULP's were conducting neuro checks for R2 after a fall. R6's Neurological Flow Sheet dated May 10, 2022, identified ULP's were conducting neuro checks for R6 after a fall. ULP-F had a hire date of April 7, 2022. ULP-F's record lacked evidence of training and competency for the treatment of black compression wraps and Rooke vascular boot for R1 and mechanical soft diet for R3. ULP-G had a hire date of May 4, 2021. ULP-F and ULP-G's records lacked evidence of training and competency for the delegated tasks of Freestyle Libre sensor and neurological checks. On June 2, 2022, at 11:38 a.m., registered nurse (RN)-B stated she had trained ULP-F and ULP-G "step by step verbally" and ULP-F and ULP-G "were competent to perform" the delegated task of Freestyle and neuro checks, but she had "no documentation of training or competency".	0 650		

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0 650	Continued From page 14 The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration dated July 19, 2021, indicated the RN would document the training and competency of unlicensed personnel to competently administer each type of service they are assigned in the staff person's personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 730 SS=E	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	0 730		

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0 730	Continued From page 15 resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of content in the resident's record as required for three of three residents (R1, R2, R3) with records reviewed. 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	0 730		

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0 730	Continued From page 16 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's record lacked documented address information for emergency contact and health and medical service providers. R1's Elder Profile dated June 1, 2022, listed "emergency" contact and "Primary Physician, Pharmacy, Hospital" names and phone numbers, but lacked the addresses. R2 R2's record lacked documented address information for emergency contact and health and medical service providers. R2's Elder Profile dated June 1, 2022, listed "emergency" contact, "case worker" and "Pharmacy, Hospital" names and phone numbers, but lacked the addresses. R3 R3's record lacked documented address information for health and medical service providers. R3's Elder Profile dated June 1, 2022, listed "Primary Physician, Pharmacy, Hospital" names and phone numbers, but lacked the addresses. On June 2, 2022, at 12:27 p.m., registered nurse (RN)-B stated she was the person who "put the information into the system" for the residents' emergency contact and health and medical service providers. RN-B confirmed R1, R2 and R3's records lacked the addresses for the above.	0 730		

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0 730	Continued From page 17 RN-B stated the "information would show on the Elder Profile sheet". RN-B stated, "I can put in the addresses". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	0 780		

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0 780	Continued From page 18 Based on observation and interview, the licensee failed to provide a smoke alarm outside within the vicinity of the bedroom of resident apartment unit #12 of building 2 as required by Minnesota Statutes, 144G.45, Subd. 2. This has the potential to directly affect resident, 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 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 June 2, 2022, from approximately 9:40 a.m. to 11:50 a.m., survey staff toured buildings 1 and 2 with the housing manager (HM)-C. At approximately 11:35 a.m., survey staff toured the one-bedroom apartment unit #12 of building 2 and observed there was no smoke alarm provided outside within the vicinity of the bedroom. Survey staff explained to the HM-C that a smoke alarm is also required outside within the vicinity of the bedroom and must also be interconnected with the smoke alarm inside the bedroom so when one smoke alarm is activated, both alarms will sound. The HM-C verified the finding. On June 2, 2022, at approximately 12:20 p.m., the HM-C acknowledged the above finding at the exit interview. No other information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		

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0 790	Continued From page 19	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 2, 2022, from approximately 9:40 a.m. to 11:50 a.m., survey staff toured buildings 1 and 2 with the housing manager (HM)-C. During the	0 790		

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0 790	Continued From page 20 tour, survey staff observed that the portable fire extinguishers for buildings 1 and 2 were tagged with last annual service date of June 2021, but all extinguishers lacked records to show the required monthly visual inspections. The HM-C verified the findings. On June 2, 2022, at approximately 12:20 p.m., the HM-C acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 810 SS=D	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.	0 810		

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0 810	Continued From page 21 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the required documentation on fire protection procedures for residents as part of the fire safety and evacuation plan. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 June 2, 2022, at approximately 12:00 p.m., survey staff reviewed the facility's fire safety and evacuation plan documentation, training policies and procedures, and related records. Document review showed the licensee lacked the required documentation on fire protection procedures for	0 810		

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0 810	Continued From page 22 residents. On June 2, 2022, at approximately 12:20 p.m., the housing manager-C acknowledged the above finding at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=H	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 23 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) had completed and/or documented a comprehensive assessment for change in condition for three of three residents (R1, R2, R6) related to falls. In addition, the licensee failed to ensure the RN conducted reassessment and monitoring no more than 14 calendar days after initiation of services for one of three residents (R2) and had conducted assessment for self-administration of medications for three of three residents (R1, R2, R3), with records reviewed. 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: R1 R1's record lacked evidence the RN had conducted an assessment of the resident for a change in condition related to falls and ER visit following falls, including assessment for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury. In addition, R1's record lacked evidence the RN had conducted assessment for self-administration of medication.	01620		

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01620	Continued From page 24 R1 diagnoses included essential hypertension, diabetes, chronic pain, repeated falls. R1's Elder Service Agreement dated May 24, 2022, indicated R1 received services which included assist with elevate legs, leg wraps, bed making, physical assist during activities, bathing, physical assist to and from dining, dressing, nail care, grooming, behavior, monthly weight and vitals, weight monitoring, housekeeping, personal laundry, blood sugar monitoring, medication administration, oxygen, transfers, toileting, assist to and from smoking area and wellness checks. On June 1, 2022, at 7:12 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medication to R1. On June 1, 2022, at 8:55 a.m., R1 stated, "Yeah" to having fallen previously. R1 stated, "If I fall I'm dehydrated or loose my balance due to having no toes on my left foot or my hemoglobin is low. I have had blood transfusions." R1 stated, "I fell three times on Christmas. I was dehydrated. I went to the hospital. I can't remember if I was admitted." R1 stated when she falls staff "check vitals and assess what's going on". R1's record included the following Resident Incident Reports and Progress Notes: -December 25, 2021, at 10:00 a.m. fell in bedroom. Was trying to get coat, lost balance and fell. No injury. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: staff instructed to monitor." -December 25, 2021, at 10:45 a.m. fell in bedroom. Trying to get up for bathroom and just	01620		

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fell. Bruise found. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: sent to ER [emergency room] for evaluation."
-December 25, 2021, at 11:25 p.m. fell in bedroom. I was trying to get out of bed then I fell as I was trying to reach the chair. No injury. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: evaluated at ED [emergency department] earlier in the day."
-March 12, 2022, at 12:40 p.m. fell in bathroom. She was putting away items she had just bought into the lower left drawer of bathroom sink. Fell standing back up she lost balance and fell backwards onto her butt. No injury. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach. Comments: history of multiple falls."

R1's record included the following comprehensive assessments completed related to the above falls:
-December 26, 2021, change in condition: three falls and ED visit, indicated fall risk evaluation points scored was 11 total. The assessment indicated total score of 10 or above represents high risk and was answered "No".

Although an Incident Investigation was completed for the above falls, R1's record lacked documented evidence by the RN of determined or potential causative factors to determine specific interventions to minimize the risk for future falls and potential injury as evidenced by the "Resident

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follow up and prevention: Fall reduction interventions implemented" remained the same with no documentation indicating if the interventions were effective or not.

On May 31, 2022, at 11:13 a.m., during the entrance conference registered nurse (RN)-B stated when a resident falls "staff call nurse, check vitals/range of motion and I instruct if no injuries. If injury staff call 911. If resident hits their head neuro's are checked for the first 24 hours. I notify the doctor/family/caseworker and chart on it. Staff do the incident report and I complete it." RN-B stated she did "analysis" for root cause of falls and implemented "interventions if can to prevent falls".

On June 2, 2022, at 12:27 p.m., RN-B stated regarding falls, R1 "has a call pendent at all times for assist, we encourage hydration, tell her to go slow when dizzy and ask for assist as that is what she is here for".

SELF ADMINISTRATION MEDICATION
R1's Physician Order Sheet dated May 12, 2022, included an order for Chlorhexidine 0.12% (percent) swish and spit 15 "ml's" (milliliters) twice a day.

On June 1, 2022, at 7:12 a.m. unlicensed personnel (ULP)-F was observed to pour 15 ml's of Chlorhexidine into a medication cup. ULP-F entered R1's apartment and administered oral medications to R1. ULP-F placed the medication cup with Chlorhexidine on top of R1's bathroom sink countertop and informed R1 where the medication was located for R1 to take later. ULP-F stated R1"let's staff know when she is done eating" and then staff "set up toothbrush" for R1 to "brush teeth" and R1 would the use the

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Chlorhexidine medication to rinse out moth. ULP-F stated, "Sometimes [R1] refuses" the medication. ULP-F left R1's apartment and the Chlorhexidine medication remained on the bathroom sink countertop.

R1's Uniform Assessment Tool dated May 30, 2022, indicated R1 was "deemed able to partially safely self-administer as needed inhaler medication at bedside.

R1's record lacked an assessment by the RN for self-administration for the Chlorhexidine medication.

On June 2, 2022, at 12:27 p.m., RN-B stated staff "are told to never leave medication". RN-B stated residents were not able to self-administer medications without a physician order. RN-B confirmed R1 lacked assessment for self-administration of the Chlorhexidine medication.

R2
R2's record lacked evidence the RN had conducted an assessment of the resident for a change in condition related to falls, including assessment for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury. In addition, R2's record lacked reassessment and monitoring no more than 14 calendar days after initiation of services by the RN and lacked documented evidence the RN had conducted assessment for self-administration of medication.

R2 diagnoses included hypertension, seizures and diabetes.

R2's Elder Service Agreement dated December

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01620	Continued From page 28 20, 2021, , indicated R2 received services which included assist with bathing, activity reminders, dining set-up, TED hose (compression stockings), denture care reminders, nail care, behavior, monthly weight and vitals, housekeeping, personal/linen laundry, CPAP(continuous positive airway pressure), oxygen, medication administration, transfers, safety checks, wellness checks and toileting. On June 1, 2022, at 8:23 a.m. ULP-F was observed to administer medication to R2. On June 1, 2022, at 8:35 a.m. R2 stated, "Yes, I've fallen I hit my head on the window or something over there. The checked me every 15 minutes for quite a while, then every one half hour. It's not the first time I've fallen. I've fallen four times here. It has to do with balance. I have so many medicines. I meet with the neurologist this month and will see what they can do. I see a headache neurologist." R2's record included the following Resident Incident Reports, Progress Notes and physician orders: -January 3, 2022, at 9:00 p.m. fell in bedroom. Resident stated she lost her balance and tried to catch herself on her rocking chair last night but still fell. She stated she did not hit her head, but hit her left arm. Complaints of pain. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: encouraged client to notify staff right away (not the next day)." -Progress Note dated January 4. 2022, documented by RN-B, client seen multiple staff but did not state she fell last eve until this	01620		

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morning after breakfast, denied hitting head but did hit left elbow and utilizing a cold pack. Encouraged to notify staff immediately.
-physician order dated January 5, 2022, physical and occupational therapy (PT/OT) to evaluate and treat gait instability and falls due to generalized weakness and generalized osteoarthritis of multiple joints.
-Progress note dated January 11, 2022, client seen by PT yesterday and she declined OT.
-April 3, 2022, at 10:30 p.m. fell in bedroom. Resident explained she was walking to her chair from her mini fridge and her left leg gave out. She complained of pain in left leg and her right wrist. She said she landed on her wrists as she was trying to catch her fall an that's why its aching in reference to right wrist pain. She was not sure if she did or did not hit her head. Ice pack was given for pain, resident refused medication for pain. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness. Comments: encouraged client to always use wheeled walker."
-Progress note April 4, 2022, documented by RN-B Denied hitting head at first, but later said she did. Neuro's initiated. Staff gave ice pack.
-April 29, 2022, at 7:45 p.m. fell in bathroom. She lost her balance and fell, hit her head on the bathtub. Started neuro checks and gave her Tylenol. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: encouraged client to keep call pendent light with her always."
-Progress note April 29, 2022, documented by RN-B client had got herself up into recliner before calling staff because she had forgotten her call

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pendent light or phone.
-May 11, 2022, at 6:15 a.m. fell in bedroom. The resident stated she went to get up from the bathroom and lost her balance. The resident fell forwards and hit her head on the side of the bench, hit her shoulder, and the back of knee. 15 minute neuro checks started and vitals taken. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: History of multiple falls at home and here."
-Progress note May 11, 2022, at 6:56 a.m. documented by RN-B, at 6:15 a.m. staff stated client in chair and stated she had got up to go to the bathroom and lost her balance and fell. Did hit left side of head, shoulder and back of knee.

R2's record included the following comprehensive assessments:
-December 20, 2021, Uniform Assessment Tool (Initial Assessment) indicated fall risk evaluation total points scored was nine (9) elder does not require fall risk safety checks.
-February 9, 2022, Uniform Assessment Tool (14 day assessment) indicated fall risk evaluation total points scored was nine (9) elder does not require fall risk safety checks.
-March 30, 2022, Uniform Assessment Tool (90 day assessment) indicated fall risk evaluation total points scored was nine (9) elder does not require fall risk safety checks.

Although an Incident Investigation was completed for the above falls, R2's record lacked evidence of a documented assessment by the RN for a change in condition related to the falls as above, including review for potential causative factors and to determine specific interventions to

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minimize the risk for future falls and potential injury. The "Resident follow up and prevention: Fall reduction interventions implemented" remained the same with no documentation indicating if the interventions were effective or not.

On June 2, 2022, at 12:27 p.m., RN-B stated, "No" she had not completed a comprehensive assessments for the above falls. RN-B stated, "That is not part of our system". RN-B stated, "If go to ER that is a change in condition" an assessment would be completed then. RN-B stated. "I did not know I was supposed to do" a comprehensive assessment for fall with injuries. RN-B stated, "Now I know I need to do". RN-B stated, "we try to keep clutter clear for her. We put a night light in the bathroom. I did not document it." RN-B stated she "never seen marks on head after she tells us she fell".

14 DAY ASSESSMENT
R2's record indicated the assessments by the RN were completed as follows:
- December 20, 2021, Uniform Assessment Tool (Initial Assessment)
- February 9, 2022, Uniform Assessment Tool (14 day assessment) (43 days after initiation of services)

On June 2, 2022, at 12:27 p.m., RN-B stated assessments automatically pop up on the facility computer system when they are due. RN-B stated when the assessments come up she "tries to get them done early". RN-B stated, "I don't know if it's something in the system" regarding why R2's 14 day assessment was completed late.

On June 3, 2022, at 11:18 a.m., housing manager (HM)-C stated R2 was admitted on December 20,

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2021, but R2 did not have her chair, so R2 went on a leave of absence on December 20, 2021, and came back to the facility on December 28, 2021, which was the first day services were provided.

SELF ADMINISTRATION MEDICATION
R2's Clinic note dated May 17, 2022, indicated "may keep at bedside/bedtime and self-administer as needed" for artificial tears (used to treat dry eyes), Debrox 6.5% solution (used to clear wax out of ears), hot original pain relief 2.5% gel, muscle rub 10-15% cream, pepto-bismol and Vicks Vapor Rub ointment.

R2's Uniform Assessment Tool dated March 30, 2022, indicated R2 was "deemed unable to safely self-administer medications for the following reasons: need routine scheduled and correct times."

R2's record lacked an assessment by the RN for self-administration for the above mentioned mediations.

On June 3, 2022, at 12:45 p.m., RN-B stated, "I did not change it on her last 90 day assessment for self-administration. I will change it. She is able to do".

R6
R6's record lacked evidence the RN had conducted an assessment of the resident for a change in condition related to falls, including assessment for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury.

R6 diagnoses included anxiety disorder, bradycardia, diabetes, repeated falls, and

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01620	Continued From page 33 unsteadiness on feet. R6's Elder Service Agreement dated May 12, 2022, indicated R6 received services which included CPAP cleaning, activity reminders, bed making, clean bathroom, bathing reminders, nail care, behavior, monthly weight and vitals, housekeeping, linen/personal laundry, medication administration, lab result monitoring and safety/wellness checks. R6's record included the following Resident Incident Reports and Progress Notes: -January 17, 2022, at 3:35 a.m. fell in hallway. Resident stated he fell due to loss of balance from his legs giving out. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: history of multiple falls and multiple times, has worked with PT/OT." -February 16, 2022, at 2:02 a.m. fell in "other". Resident stated he was trying to look for his keys to get in the front door and he couldn't find them because the light was off, had trouble finding the keyhole and his legs got weak and he fell. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: is getting new diabetic shoes." -Progress Note dated February 16, 2022, documented by RN-B, did have wheeled walker and shoes on. Right ankle had two marks but no swelling or redness. -March 30, 2022, at 3:40 a.m. fell in bedroom. Resident stated he was moving from his walker to his chair and his legs gave out and he lost his	01620		

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balance and fell backwards onto the floor. Resident stated he was not hurt. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: history of multiple falls and courses of PT/OT."
-March 30, 2022, at 3:40 a.m. fell in bedroom. Resident stated he was moving from his walker to his chair and his legs gave out and he lost his balance and fell backwards onto the floor. Resident stated he was not hurt. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: history of multiple falls and courses of PT/OT."
-Progress Note dated March 30, 2022, at 8:52 a.m. documented by RN-B, client complained this morning of thigh weakness. Vital signs documented. No facial droop, equal and strong hand grasps, able to wiggle toes, ankles, move legs up and down at knees. Talked to him about drinking coffee 24 hours and no other beverages, educated on dehydration and had client drink a large glass ice water and shortly thereafter he was fine.
-April 16, 2022, at 1:12 p.m. fell in bedroom. Resident stated he was standing by his wheeled walker and his right leg started feeling weak and he fell. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: history of multiple falls and multiple PT/OT."
-April 16, 2022, at 1:12 p.m. fell in bedroom. Resident stated he was standing by his wheeled

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walker and his right leg started feeling weak and he fell. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: history of multiple falls and multiple PT/OT."
-Progress Note dated April 16, 2022, at 4:41 p.m. documented by RN-B, denies hitting head and denies pain.
-April 17, 2022, at 2:55 a.m. fell in hallway. Resident stated he was coming inside the house and tried to unlock the door and his legs gave out and felt weak. Resident stated he could not hold his balance and he fell backwards. Resident stated he did not hit his head and had no other injuries. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: history of previous falls."
-Progress Note dated April 17, 2022, at 7:47 a.m. documented by RN-B, staff reported last eve at 9:30 p.m. client received 1800 milligram (mg) dose of oxcarbazapine (used to treat mood) instead of scheduled dose 900 mg. vitals documented.
-May 10, 2022, at 2:30 a.m. fell in bedroom. Resident stated he was trying to make it to his chair when his legs gave out and he lost his balance. He said he fell backwards and hit his head on the doorframe. Checked for injuries, neuro checks started. "Resident follow up and prevention: Fall reduction interventions implemented: articles of need within reach, bed and furniture height assessed for appropriateness, call cord or other device within easy reach. Comments: history of multiple prior falls."

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01620	Continued From page 36 -Progress Note dated May 10, 2022, at 6:37 a.m. documented by RN-B, staff heard noise and when entering clients room noted him on the floor. He stated his legs got weak, he lost his balance going to his chair and fell backwards hitting his head on the door frame. No marks/bumps noted. Vitals documented (same as documented at time of fall). Neuro checks started. R6's Uniform Assessment Tool dated April 11, 2022, (change of condition assessment: ED visit with admit April 7, 2022 and return April 11, 2022) indicated fall risk evaluation total points scored was 15 and elder does not require fall risk safety checks. Although an Incident Investigation was completed for the above falls, R6's record lacked evidence of a documented assessment by the RN for a change in condition related to the falls as above, including review for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury. The "Resident follow up and prevention: Fall reduction interventions implemented" remained the same with no documentation indicating if the interventions were effective or not. On June 2, 2022, at 12:15 p.m., RN-B stated for falls "staff fill out the incident record" at the time of the fall. RN-B stated she "completed the incident investigation, talks with the client and lets the doctor and family know about the fall." RN-B stated R6 "has had PT and OT onsite and offsite multiple times. [R6] starts it and then says he doesn't want to continue. They gave exercises and he is non-compliant. We encourage to use call pendent. [R6] is a 24-hour coffee drinker. We	01620		

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01620	Continued From page 37	01620		

encourage hydration." RN-B stated R6 was "alert and orientated." RN-B stated R6 "falls off site, goes out a lot". RN-B stated R6 did receive his diabetic shoes. RN-B stated she would look for more information about the above falls, including documentation for comprehensive assessments being completed after the falls. No other information was provided.

R3
R3's record lacked evidence the RN had conducted assessment for self-administration of medication.

R3's Medication Administration Record (MAR) dated May 2022, included antifungal 2% (Monistat) cream apply topically as needed for itching.

R3's Clinic note dated May 4, 2022, included miconazole nitrate (Monistat) 2% cream apply sparingly to affected areas.

R3's Uniform Assessment Tool dated May 24, 2022, indicated R3 was "deemed unable to safely self-administer medications for the following reasons: to ensure proper dosage and scheduled times."

R3's record lacked an assessment by the RN for self-administration for the above mentioned mediations.

On June 2, 2022, at 12:27 p.m., RN-B stated, "She does, self-administers" the antifungal cream. RN-B stated she would look for an assessment for self-administration.

On June 3, 2022, at 1:11 p.m., RN-B stated, "There is no self-administration assessment" for

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01620	Continued From page 38 the antifungal cream. RN-B stated, "I will get orders clarified. I did not change the last 90 day assessment." The licensee's Resident Pre-Admission Assessment and Monitoring Process Nursing policy dated July 20, 2021, indicated the RN would complete a resident reassessment no more than 14 calendar days after initiation of services. The licensee's Initial and On-Going Nursing Assessment of Residents under the Comprehensive Licensed Agency policy dated July 20, 2021, indicated nursing assessments were completed by a RN based upon the required assessment schedule and as needed based upon resident condition. The RN would complete a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs as required for change in resident condition. The licensee's Orientation and Training Fall Risk and Prevention dated August 1, 2021, indicated it is important that after each fall, including near falls and incident report is completed and forwarded to the RN. The RN was responsible following up on falls, including completing a fall risk assessment, if necessary, and attempting to identify the causes of the fall and implement interventions to reduce the risk f future falls and injury (this is referred to as a root cause analysis). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01640	Continued From page 39	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan was revised, based on resident reassessment for two of three residents (R1, R2) with records reviewed. 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	01640		

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01640	Continued From page 40 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: R1 R1's Elder Service Agreement lacked revision for treatment services of Rooke vascular boot (treats and prevents lower extremity skin breakdown). R1's Uniform Assessment Tool dated May 30, 2022, lacked assessment for the use of Rooke vascular boot. R1's Medication Administration Record (MAR) dated May 2022, identified staff were signing for the treatment and therapy administration of Rooke vascular boot to right lower extremity at bedtime and removal in the morning. R1's record included physician orders dated May 12, 2022, which included Rooke vascular boot right lower extremity apply and remove in the morning. R1's Elder Service Agreement dated May 24, 2022, indicated R1 received assistance by staff to put on left leg wrap every day, staff were to perform fasting blood glucose (FSBG) four times a day per physician order, assist with oxygen administration and assist with elevating legs. R1's Elder Service Agreement lacked revision to include the treatment service for Rooke vascular boot. R2 R2's Elder Service Agreement lacked revision for	01640		

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01640	Continued From page 41 treatment services of oxygen and TED's (compression stockings). R2's Uniform Assessment Tool dated December 20, 2021, indicated R2 used oxygen therapy and R2 required assistance with use of oxygen. R2 had the following treatments ordered by a provider and were provided by the facility which included "compression garments PRN" (as needed) and assistance needed was full assist. On June 1, 2022, at 8:25 a.m., the surveyor observed R2 seated in a recliner. An oxygen concentrator was observed in R2's apartment. R2 stated the licensee staff assisted to "turn on oxygen at night and turn off oxygen in the a.m. and help with tubing (oxygen) if needed". R2's Elder Service Plan effective date June 1, 2022, indicated service of TED hose PRN and required physical assist of one to pull on and remove compression hose. "02" (oxygen) safety check for the times of "PM" and "NOC" (night) to check for safe storage of oxygen tanks and cleanliness of equipment. R2's Medication Administration Record dated May 2022, identified ULP's were signing for the administration of "oxygen at night with CPAP [continuous positive airway pressure] continuous at 2 liters". R2's record included physician orders dated December 17, 2021, which included compression socks PRN daily and oxygen at 2 liters at night. R2's Elder Service Agreement dated December 20, 2021, indicated service type: TED hose for the times of a.m. and p.m. every day, physical assist of one to assist to pull on and remove	01640		

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01640	Continued From page 42 compression hose and service type 02 safety check for the times of p.m. and noc every day, check for safe storage of oxygen tanks and cleanliness of equipment. R2's Elder Service Agreement lacked revision to include the treatment service for administration of oxygen and change of service to PRN for the treatment service of TED hose. On June 2, 2022, at 12:27 p.m., registered nurse (RN)-B stated R1 "was using" Rooke boot as indicated on R1's MAR. RN-B reviewed R2's service agreement and stated, "I can add on there" for the treatment service of providing assistance with oxygen administration. RN-B stated the physician order for R2's TED's was PRN. RN-B stated regarding R2's service agreement needing revision for the treatment services of oxygen and TED's, "I'll change and have [R2] sign". The licensee's Contents of Service Plans policy dated July 20, 2021, indicated all residents would have an up to date service plan identifying services to be provided based on the assessment by the RN. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each	01650		

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01650	Continued From page 43 service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R1, R2, R3) with records reviewed. 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	01650		

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01650	Continued From page 44 or has the potential to affect a large portion or all of the residents). The findings include: R1, R2 and R3's service plans lacked evidence of documented information and a method to contact the facility and R3's service plan lacked the treatment service of specialty diet. R1 R1's Elder Service Agreement dated May 24, 2022, lacked information and a method to contact the facility. R2 R2's Elder Service Agreement dated December 20, 2021, lacked information and a method to contact the facility. R3 R3's Elder Service Agreement dated May 10, 2022, lacked information and a method to contact the facility. R3's Uniform Assessment Tool dated May 24, 2022, identified for "indicate any concerns that may affect the elder's ability to eat or drink: altered swallowing": did have a swallow evaluation and recommended nectar thick liquids, but refused to comply and was discontinued. Diet Texture of Mechanical Soft. R3's Treatment /Therapy Management Plan dated April 4, 2022, indicated the "treatments/services provided/delegated to ULP" included "specialty diet (describe): mechanical soft" and Medication Administration Record dated May 2022, indicated "Diet: mechanical Soft"; however, R3's Elder Service Agreement lacked	01650		

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01650	Continued From page 45 documented evidence of providing the treatment service of mechanical soft diet, including the fees for the service, the frequency of the service and the identification of staff or categories of staff who would provide the service. On June 1, 2022, at 9:15 a.m. R3 was observed to be in bed resting. R3 stated, "I need meats cut up". R3 stated, "I had thick-it for swallowing. I don't like it". On June 2, 2022, at 12:27 p.m., registered nurse (RN)-B stated, "I don't see it", regarding R1, R2 and R3's service agreement including information and a method to contact the facility. RN-B stated all residents service agreements would lack the same. RN-B confirmed R3's service agreement lacked the treatment service of specialty diet. RN-B stated R3 had a mechanical diet "when [R3] was admitted" to the facility. The licensee's Contents of Service Plans policy dated July 20, 2021, indicated all residents would have an up-to-date service plan identifying services to be provided based on the assessment by the RN. The service plan would include the required elements of information and a method to contact the facility, a description of the services provided, fees for services and frequency of each service. The policy did not address the required element of identification of staff or categories of staff who would provide the services. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01650		

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01730	Continued From page 46	01730		
01730 SS=E	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 (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	01730		

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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 ensure an individualized medication management plan to include all required content for three of three residents (R1, R2, R3) with records reviewed.

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:

R1, R2 and R3's medication management plans lacked procedures for staff to notify the registered nurse (RN) when a problem arises for the administration and documentation of specific resident instructions related to the administration of medications.

R1
R1's Elder Service Agreement dated May 24, 2022, indicated R1 received insulin, oral and inhaler medication administration services.

On May 31, 2022, at 1:01 p.m., the surveyor

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01730	Continued From page 48 observed unlicensed personnel (ULP)-F administer medication to R1. R1's Medication Administration Record (MAR) dated May 2022, indicated R1 received four medications to treat high blood pressure, one used as preventative, two used for seizure, one used for oral hygiene, one used to prevent blood clots, two used to reduce cholesterol, one used to treat anemia, one used for depression, two used to reduce fluid retention, four used for constipation, two used to treat diabetes, three used for pain, one used to treat acid reflux, one used to treat low potassium, one used to treat restless leg syndrome, one used to treat mood, two used to treat difficulty breathing, one used to treat vitamin D deficiency, one used for anxiety, one used for heartburn, one used for allergies, one used for muscle spasms, one used for diarrhea, one used for chest pain, one used for dry eyes, one used for cough and one used for dry skin. R1's Medication Assessment and Medication Management Plan was dated February 16, 2021. The plan indicated medications would be administered by facility staff and for "Nurse notification when problem arises: unlicensed professionals will contact the licensed nurse 24/7 with any questions or concerns with medication administration. Documentation: Any elder specific requirements related to documentation of medication are located: on the medication administration record (MAR); on the electronic medication record (eMAR); other: Elder chart". R1's Medication Management Plan failed to indicate procedures for staff to notify the registered nurse (RN) when a problem arises for the administration of as needed (PRN)	01730		

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nitroglycerin (used to treat chest pain) medication. In addition, R1's MAR lacked specific instructions for parameters of which PRN medication to administer first for constipation and pain and lacked parameters for administration of PRN Maalox (used to treat heartburn) for the dose to be administered (15 to 30 milliliters) as indicated on R1's medication management plan.

R2
R2's Elder Service Agreement dated December 20, 2021, indicated R1 received oral medication administration services.

On June 1, 2022, at 8:23 a.m., the surveyor observed ULP-F administer medication to R2.

R2's MAR dated May 2022, indicated R2 received one medication to reduce fluid retention, three used for seizures, one used to treat low thyroid level, one used to treat high blood pressure, one used for insomnia, one used for acid reflux, one used to treat vitamin D deficiency, one used to treat kidney stones, one used for depression, three used for migraine, one used for anxiety, one used for hemorrhoids, one used for headaches, one used for pain and one used for constipation.

R2's Medication Assessment and Medication Management Plan was dated December 20, 2021. The plan indicated medications would be administered by facility staff and for "Documentation: Any elder specific requirements related to documentation of medication are located: on the medication administration record (MAR); on the electronic medication record (eMAR)".

R2's MAR lacked specific instructions for parameters of which PRN medication to

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administer first for migraine and headache, lacked parameters for administration of PRN Tylenol (used to treat pain) for the dose to be administered (one or two tablets), lacked parameters for administration of PRN Ativan (used to treat anxiety) for hours between doses (one tablet PRN, may take up to two tablets per day) and lacked parameters for administration of PRN naproxen (used to treat pain) for hours between doses (one tablet two times daily PRN) as indicated on R2's medication management plan.

R3
R3's Elder Service Agreement dated May 10, 2022, indicated R3 received inhaler, and oral medication administration services.

On May 31, 2022, at 1:24 p.m., the surveyor observed ULP-G administer medication to R3.

R3's MAR dated May 2022, indicated R3 received two medications for pain, one used to treat anemia, one used to treat atrial fibrillation, two used to treat breathing, four used for supplement, one used to reduce fluid retention, one used for arthritis, one used for acid reflux, one used for depression, one for prophylactic, one used for diarrhea, one used for itching, one used for indigestion, one used for lubricant, one used for cough, one used for dry nasal and one used for sore throat.

R3's Medication Assessment and Medication Management Plan was dated February 22, 2021. The plan indicated medications would be administered by facility staff and for "Nurse notification when problem arises: unlicensed professionals will contact the licensed nurse 24/7 with any questions or concerns with medication

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administration" and "Documentation: Any elder specific requirements related to documentation of medication are located: on the medication administration record (MAR); on the electronic medication record (eMAR)".

R3's MAR identified R3 received PRN Tylenol 500 milligrams (mg) two tablets on May 13, 2022, at 5:06 p.m. for pain and was administered a scheduled dose of Tylenol 500 mg two tablets at 8:00 p.m. (2 hours and 54 minutes between doses).

R3's Medication Management Plan failed to indicate procedures for staff to notify the registered nurse (RN) when a problem arises for the administration of Eliquis (prevents blood clots) medication. In addition, R3's MAR lacked specific instructions for parameters for hours between doses acetaminophen 500 mg scheduled (two tablets three times a day at 7 a.m., 2 p.m., 8 p.m.) and PRN Tylenol (two tablets every six hours); parameters for hours between doses oxycodone 5 mg scheduled (once daily at bedtime) and PRN oxycodone (once daily); parameters for which PRN medication (Tylenol or oxycodone) to administer first for pain; parameters for albuterol (used to treat breathing) for hours between doses (every 4 to 6 hours PRN); parameters for Imodium (used to treat diarrhea) for hours between doses (take one tablet up to three times daily PRN); parameters for antifungal 2% cream for frequency of hours (apply as needed for itching); parameters for saline nasal spray for hours between doses (two sprays in each nostril three times daily); parameters for Chloraseptic (sore throat spray) for frequency of hours (one spray to the mouth or throat as needed); parameters for Triad wound dressing paste for frequency of hours (apply to

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affected area of left ear as needed) as indicated on R3's medication management plan.

On June 2, 2022, at 12:27 p.m., RN-B stated there were "no directions which to give first" for PRN medications as noted above and for medications with dose ranges the staff would "call the nurse"; however R1, R2 and R3's medication management plans lacked to indicate to call the nurse first for dose ranges. RN-B stated for R3's Eliquis, when to notify the nurse "I can add that". RN-B stated, "I'll have to fax the doctor to clear order up". RN-B confirmed R1, R2 and R3's medication management plans lacked the above.

The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated July 20, 2021, indicated the RN may delegate to unlicensed personnel the administration of medications if the unlicensed personnel if the RN has developed written, specific instruction for each client.

The licensee's Delegation of Nursing Tasks 2.0 policy dated July 14, 2021, indicated when needed the RN would provide written specific instructions for performing the procedure to the ULP.

The licensee's Delegation of Nursing Tasks 4.0 dated July 20, 2021, indicated the RN may delegate medication administration to unlicensed personnel only after the RN has developed specific written instructions for each resident and documented those instructions in the resident's medication record/MAR.

The licensee's Administration and Documentation of PRN Medications policy dated July 19, 2021, indicated PRN medications would be

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01730	Continued From page 53 administered consistent with parameters specified in the prescriber's prescription and with procedures identified by the RN for the administration and documentation of the PRN. If the parameters for the PRN medication are unclear the RN would follow up with the prescriber to obtain the necessary clarification. 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 and the registered nurse (RN) specified, in writing, specific instructions for three of three residents (R1, R2, R3) for administration of medications, with records reviewed.	01750		

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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:

R1
R1's Elder Service Agreement dated May 24, 2022, indicated R1 received insulin, oral and inhaler medication administration services.

On May 31, 2022, at 1:01 p.m., the surveyor observed unlicensed personnel (ULP)-F administer medication to R1.

R1's Medication Administration Record (MAR) dated May 2022, indicated R1 received four medications to treat high blood pressure, one used as preventative, two used for seizure, one used for oral hygiene, one used to prevent blood clots, two used to reduce cholesterol, one used to treat anemia, one used for depression, two used to reduce fluid retention, four used for constipation, two used to treat diabetes, three used for pain, one used to treat acid reflux, one used to treat low potassium, one used to treat restless leg syndrome, one used to treat mood, two used to treat difficulty breathing, one used to treat vitamin D deficiency, one used for anxiety, one used for heartburn, one used for allergies, one used for muscle spasms, one used for diarrhea, one used for chest pain, one used for dry eyes, one used for cough and one used for

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01750	Continued From page 55 dry skin. R1's Medication Assessment and Medication Management Plan was dated February 16, 2021. The plan indicated "Documentation: Any elder specific requirements related to documentation of medication are located: on the medication administration record (MAR); on the electronic medication record (eMAR); other: Elder chart". R1's MAR lacked specific instructions for parameters of which PRN medication to administer first for constipation and pain and lacked parameters for administration of PRN Maalox (used to treat heartburn) for the dose to be administered (15 to 30 milliliters). In addition, R1's MAR indicated "weigh every day before breakfast. Notify nurse of a weight gain or loss of 3-5 [three to five] lbs [pounds] or more in 24 hours". Weights documented included 256 pounds on May 7, 2022, and 253 pounds on May 8, 2022 (three pound loss in one day), 254 pounds on May 16, 2022, and 250 pounds on May 17, 2022 (four pound loss in one day), 249 pounds on May 18, 2022, and 252 pounds on May 19, 2022 (three pound gain in one day) and 249 pounds on May 20, 2022 (three pound loss in one day from May 19). There were no documented daily weights on the MAR for the dates of May 21 through May 28 and May 31, 2022. R1's record lacked documentation the RN had been notified of the weight changes in one day and a reason why no weights were obtained as delegated. R2 R2's Elder Service Agreement dated December	01750		

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01750	Continued From page 56 20, 2021, indicated R1 received oral medication administration services. On June 1, 2022, at 8:23 a.m., the surveyor observed ULP-F administer medication to R2. R2's MAR dated May 2022, indicated R2 received one medication to reduce fluid retention, three used for seizures, one used to treat low thyroid level, one used to treat high blood pressure, one used for insomnia, one used for acid reflux, one used to treat vitamin D deficiency, one used to treat kidney stones, one used for depression, three used for migraine, one used for anxiety, one used for hemorrhoids, one used for headaches, one used for pain and one used for constipation. R2's Medication Assessment and Medication Management Plan was dated December 20, 2021. The plan indicated "Documentation: Any elder specific requirements related to documentation of medication are located: on the medication administration record (MAR); on the electronic medication record (eMAR)". R2's MAR lacked specific instructions for parameters of which PRN medication to administer first for migraine and headache, lacked parameters for administration of PRN Tylenol (used to treat pain) for the dose to be administered (one or two tablets), lacked parameters for administration of PRN Ativan (used to treat anxiety) for hours between doses (one tablet PRN, may take up to two tablets per day) and lacked parameters for administration of PRN naproxen (used to treat pain) for hours between doses (one tablet two times daily PRN). R3 R3's Elder Service Agreement dated May 10,	01750		

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2022, indicated R3 received inhaler, and oral medication administration services.

On May 31, 2022, at 1:24 p.m., the surveyor observed ULP-G administer medication to R3.

R3's MAR dated May 2022, indicated R3 received two medications for pain, one used to treat anemia, one used to treat atrial fibrillation, two used to treat breathing, four used for supplement, one used to reduce fluid retention, one used for arthritis, one used for acid reflux, one used for depression, one for prophylactic, one used for diarrhea, one used for itching, one used for indigestion, one used for lubricant, one used for cough, one used for dry nasal and one used for sore throat.

R3's Medication Assessment and Medication Management Plan was dated February 22, 2021. The plan indicated "Documentation: Any elder specific requirements related to documentation of medication are located: on the medication administration record (MAR); on the electronic medication record (eMAR)".

R3's MAR identified R3 received PRN Tylenol 500 milligrams (mg) two tablets on May 13, 2022, at 5:06 p.m. for pain and was administered a scheduled dose of Tylenol 500 mg two tablets at 8:00 p.m. (2 hours and 54 minutes between doses).

R3's MAR lacked specific instructions for parameters for hours between doses acetaminophen 500 mg scheduled (two tablets three times a day at 7 a.m., 2 p.m., 8 p.m.) and PRN Tylenol (two tablets every six hours); parameters for hours between doses oxycodone 5 mg scheduled (once daily at bedtime) and PRN

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oxycodone (once daily); parameters for which PRN medication (Tylenol or oxycodone) to administer first for pain; parameters for albuterol (used to treat breathing) for hours between doses (every 4 to 6 hours PRN); parameters for Imodium (used to treat diarrhea) for hours between doses (take one tablet up to three times daily PRN); parameters for antifungal 2% cream for frequency of hours (apply as needed for itching); parameters for saline nasal spray for hours between doses (two sprays in each nostril three times daily); parameters for Chloraseptic (sore throat spray) for frequency of hours (one spray to the mouth or throat as needed) and parameters for Triad wound dressing paste for frequency of hours (apply to affected area of left ear as needed).

On June 2, 2022, at 12:27 p.m., RN-B stated there were "no directions which to give first" for PRN medications as noted above and for medications with dose ranges the staff would "call the nurse". RN-B stated, "I'll have to fax the doctor to clear orders up". RN-B stated weights were documented on the resident's MAR's. RN-B stated the staff "text me often" regarding weights for R1 and "if I am here, they tell me, and I tell them to give the PRN Lasix" (medication used to reduce fluid). RN-B stated the weight for R1 "may not always be accurate". RN-B stated, "I'll add documentation notified nurse" to the MAR. RN-B confirmed R1, R2 and R3's records lacked the above.

The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated July 20, 2021, indicated the RN may delegate to unlicensed personnel the administration of medications if the unlicensed personnel if the RN has developed written,

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01750	Continued From page 59 specific instruction for each client. The licensee's Delegation of Nursing Tasks 2.0 policy dated July 14, 2021, indicated when needed the RN would provide written specific instructions for performing the procedure to the ULP. The licensee's Delegation of Nursing Tasks 4.0 dated July 20, 2021, indicated the RN may delegate medication administration to unlicensed personnel only after the RN has developed specific written instructions for each resident and documented those instructions in the resident's medication record/MAR. The licensee's Administration and Documentation of PRN Medications policy dated July 19, 2021, indicated PRN medications would be administered consistent with parameters specified in the prescriber's prescription and with procedures identified by the RN for the administration and documentation of the PRN. If the parameters for the PRN medication are unclear the RN would follow up with the prescriber to obtain the necessary clarification. 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	01760		

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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 medication was administered as prescribed for two of five residents (R1, R5), observed for medication administration and failed to ensure documented site of injection for one of three residents (R1) with records reviewed.

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:

R1
R1's Physician Order Sheet dated May 12, 2022, included an order for Chlorhexidine 0.12% (percent) swish and spit 15 "mls" (milliliters) twice a day.

On June 1, 2022, at 7:12 a.m., the surveyor

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observed unlicensed personnel (ULP)-F pour 15 mls of Chlorhexidine into a medication cup. ULP-F entered R1's apartment and administered oral medications to R1, including two insulin injections into R1's left abdomen. ULP-F placed the medication cup with Chlorhexidine on top of R1's bathroom sink countertop and informed R1 where the medication was located for R1 to take later. ULP-F stated R1"let's staff know when she is done eating" and then staff "set up toothbrush" for R1 to "brush teeth" and R1 would the use the Chlorhexidine medication to rinse out moth with. ULP-F stated, "Sometimes [R1] refuses" the medication. ULP-F left R1's apartment and the Chlorhexidine medication remained on the bathroom sink countertop. ULP-F failed to administer the Chlorhexidine medication as prescribed. ULP-F stated, "No" regarding documenting the site where the insulin injections were administered.

R1's Medication Administration Record (MAR) dated May 2022, included insulin Aspart Flexpen - inject 10 units once daily with breakfast, six units once daily with lunch, eight units once daily with supper and three times daily per sliding scale.

The MAR indicted the medications were administered, but lacked documentation of the site in which the medication had been injected.

The website Insulin Routines - American Diabetes Association, copyright 2022, indicated Insulin Routines; insulin should be injected into the same general area of the body for consistency, but not the exact same place. Insulin delivery should be timed with meals to effectively process the glucose entering your system. Site Rotation; the place on your body where you inject insulin affects your blood sugar level. Insulin

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enters the blood at different speeds when injected at different sites. Insulin shots work fastest when given in the abdomen. Insulin arrives in the blood a little more slowly from the upper arms and even more slowly form the thighs and buttocks. Injecting insulin in the same general area (for example your abdomen) will give you the best results from your insulin. Don't inject the insulin in exactly the same place each time, but move around the same area. Each mealtime injection of insulin should be given in the same general area for best results. For example, giving your before breakfast injection in the abdomen each day and your before supper insulin injection in the leg each day give more similar blood sugar results. If you inject near the same place each time, hard lumps or extra fatty deposits may develop. Both of these problems make the insulin reaction less reliable. Timing; insulin shots are most effective when you take them so that insulin goes to work when glucose from your food starts to enter your blood. For example, regular insulin works best if you take it 30 minutes before you eat.

In addition, R1's MAR included furosemide (used to reduce fluid) 20 milligrams (mg) "take one tablet daily as needed for weight gain of greater than 3 to 5 pounds in 24 hours". The MAR identified the medication was administered on May 6, 9, 10, 14, 15, 16, 25 26, 27 and 30, 2022; however, R1's documented weights had not increased three to five pounds in one day on the 6th, 9, 10, 14, 15 and 16, 2022, from the documented daily weight prior to the dates (5, 8, 9, 13, 14, 15) and there were no documented daily weights on the MAR for the dates of May 21 through May 28 and May 31, 2022.

On June 2, 2022, at 12:27 p.m., registered nurse (RN)-B stated staff "are told to never leave

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medication". RN-B stated the staff were not "documenting the specific sites" for administration of injections. RN-B stated, "I know they rotate" the sites. RN-B stated the staff always ask R1 "where she wants the injection". RN-B reviewed R1's MAR and confirmed weights were not documented as above and R1 had received as needed furosemide without there being an increase in weight three to five pounds. RN-B stated, "Even though the scale was not up in weight, you could tell by swelling (edema). I directed to give" the furosemide as needed.

R5
R5's clinic visit note dated June 2, 2022, included an order for artificial tears 1.4% solution install one drop into both eyes up to six times per day. R5's MAR dated May 2022 indicated the same.

On May 31, 2022, at 1:11 p.m., the surveyor observed ULP-G administer artifact tears two drops into both of R5's eyes. At 1:22 p.m., ULP-G verified she had administered two drops into both of R5's eyes and R5's MAR read to administer one drop into both eyes. ULP-G stated, "I have really bad carpel tunnel. That was my fault".

On June 2, 2022, at 12:24 p.m., RN-B stated staff would need to be "re-educated".

The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated July 20, 2021, indicated medications always needs to be administered according to the "6 Rights", including "c. right time, e. right dose (how many milligrams, drops, etc.)".

The licensee's Delegation of Nursing Tasks 2.0 policy dated July 14, 2021, indicated when needed the RN would provide written specific

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01760	Continued From page 64 instructions for performing the procedure to the ULP. The licensee's Delegation of Nursing Tasks 4.0 dated July 20, 2021, indicated the RN may delegate medication administration to unlicensed personnel only after the RN has developed specific written instructions for each resident and documented those instructions in the resident's medication record/MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure one of three residents (R1) had signed prescriber's orders for medications with records reviewed. 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	01820		

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01820	Continued From page 65 situation has occurred only occasionally). The findings include: R1's record lacked a prescriber's order for Lasix (used to reduce fluid) and Lidocaine (used for pain). On May 31, 2022, at 1:01 p.m., the surveyor observed unlicensed personnel (ULP)-F administer Lasix 20 milligrams (mg) two tablets (40 mg total) to R1. ULP-F stated R1 had a "direction change" for the Lasix and the "change started today". R1's medication administration record (MAR) dated May 2022, indicated Lasix 20 mg take two tablets (40 mg) daily. R1's After Visit Summary dated May 29, 2022, indicated "change" furosemide 20 mg tablet "take 2 tablets (40 mg total) 2 (two) times a day for five days"; however, the After Visit Summary lacked signature of a physician for the prescription change in order. In addition, R1's MAR indicated Lidocaine 5% (percent) patch apply one patch topically once daily and identified the medication was not administered since May 20, 2022. R1's After Visit Summary dated May 20, 2022, indicated "stop taking lidocaine 5%": however, the After Visit Summary lacked signature of a physician for the prescription change in order. On June 2, 2022, at 12:27 p.m., registered nurse (RN)-B reviewed R1's After Visit Summary dated May 20 and 29, 2022 and confirmed there was no physician signature for the prescribed change in	01820		

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01820	Continued From page 66 orders for the Lasix and Lidocaine. RN-B stated "I can call and get the script from pharmacy" for the Lasix. RN-B stated she faxes the after visit summaries to the pharmacy and they are "Usually signed, if not the pharmacy will call and say they are not signed". The licensee's Implementation of Medication Prescriptions and Treatment and Therapy Orders dated July 20, 2021, indicated the RN would take necessary steps to obtain the prescriber's signature on any verbal orders or prescriptions as soon as possible and would document efforts to obtain the necessary signature. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name,	01910		

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01910	Continued From page 67 strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of all medications including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R4) with record reviewed. 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: R4's record lacked documentation of all medication disposition upon the resident's discharge from the facility. R4's Discharge Summary identified date services were initiated was June 21, 2019, and service end date was April 23, 2022. The summary indicated "summary of services provided during course of services" included "medication ministration".	01910		

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01910	Continued From page 68 R4's Record of the Inventory and Destruction of Controlled and Uncontrolled Substances sheets dated April 25, 2022, indicated "pain reliever ES [extra strength]" medication was disposed of through method of medsafe and dated April 26, 2022, indicated "hydrocodone/apap" (opioid/acetaminophen pain reliever) medication was disposed of through method of medsafe. R4's Medication Administration Record (MAR) dated April 2022, indicated the following medications were being administered to R4: one aspirin, atrovastatin (used to treat high cholesterol), citalopram (used to treat depression), vitamin D3 (supplement), lisinopril (used to treat high blood pressure), metoprolol (used to treat high blood pressure), pantoprazole (used to treat acid reflux), Tums (used to treat heart burn), pain reliever ES and hydrocodone/acetaminophen. R4's record lacked documented evidence for the disposition of all of the above medications upon discharge from the licensee's assisted living facility (except the pain reliever ES and hydrocodone/acetaminophen), including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On May 31, 2022, at 2:06 p.m., registered nurse (RN)-B stated the "other medications not signed for disposition were sent back to pharmacy". RN-B stated for medications in "pharmacy cards", the licensee "returned them to pharmacy" and "do not record disposition of them". RN-B confirmed R4's record lacked documented disposition of all medications being administered to R4 upon	01910		

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01910	Continued From page 69 discharge from services. The licensee's Disposition of Disposal of Medication policy dated July 19, 2021, indicated for disposal of unused or discontinued prescription drugs managed by the licensee "Documentation of the destruction, listing the date, quantity, name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the client's record for two years" and "Documentation of the Disposition of Medications. Staff will document the disposition or disposal of medications in the client's record". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 70 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individualized treatments or therapy management plan to include all required content for two of three residents (R1, R3) with records reviewed. 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: R1 and R3's treatment or therapy management plans lacked revision, lacked documentation of specific resident instructions and lacked procedures for staff to notify the registered nurse	01940		

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01940	Continued From page 71 (RN) when a problem arises for the administration related to the administration of treatments or therapy. R1 R1's Elder Service Agreement dated May 24, 2022, indicated R1 received assistance by staff to put on left leg wrap every day, staff were to perform fasting blood glucose (FSBG) four times a day per physician order, assist with oxygen administration and assist with elevating legs. On June 1, 2022, at 7:12 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medication to R1. ULP-F stated if R1's "Freestyle [blood glucose reading device] was low, we manually check with a glucometer". ULP-F stated the night shift assisted with putting a compression wrap on R1's left leg and if the wrap was not on R1's "leg would swell really bad". ULP-F stated R1 had a cast removed recently from her right leg and was unable to wear the compression wrap on her right leg due to swelling. ULP-F stated, "We elevate and ice [R1's] right leg 20 minutes every two hours. ULP-F stated staff assisted R1 with "oxygen". On June 1, 2022, at 8:55 a.m., the surveyor observed R1 have a black compression wrap with velcro straps on left leg. R1 stated she had a "cast" on her right leg and now had a "splint on at all times". R1 stated she had foot surgery. R1 stated the staff "monitor her blood sugar" results from her Freestyle located on her upper arm and would "check her blood sugar manually by finger stick" if the Freestyle device was not reading results right. R1 stated staff "elevate her legs in a reclining chair and ice her right leg a couple times a day". R1 stated staff "put wraps on and off" on her legs, the overnight person puts on the wraps	01940		

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01940	Continued From page 72	01940		

and the evening person takes the wraps off". R1 stated staff assisted with putting on and removal of "oxygen". R1 stated she was "not using right leg brace" at this time.

R1's Medication Administration Record (MAR) dated May 2022 and Service Delivery Record dated May 2022, identified staff were signing for the treatment and therapy administration of right lower leg brace on a.m. and off at bedtime, blood sugar checks monitoring/check four times a day, compression wraps on in a.m. and off at bedtime, Rooke vascular boot (treats and prevents lower extremity skin breakdown) to right lower extremity at bedtime and remove in morning, wound care-elevate and ice right foot 20 minutes every two hours while awake for five days (first date of signing for service May 20) and oxygen safety check.

R1's Physician Order Sheet dated May 12, 2022, included orders for compression wraps to lower extremities, Rooke vascular boot and right lower leg brace.

R1's Treatment/Therapy Management Plan was dated February 14, 2022. The plan indicated treatment/services provided were "blood glucose monitoring, brace assistance, compression garments, oxygen, specialty diet: low sodium (2 gm) [two gram]/cardiac diet/diabetic diet, wound care". Documentation: specific elder instructions related to administration of treatments/therapy is located: on the treatment administration record (TAR); in electronic health records (eTAR) or service tasks. Staff will notify a licensed nurse or appropriate licensed health professional when a problem arises with treatment/therapy management services, including refusals and potential treatment inaccuracies. Specific

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01940	Continued From page 73	01940		

parameters regarding treatments are also located: on the elder's treatment administration record (TAR); in electronic health records (eTAR) or service tasks.

R1's Treatment/Therapy Management Plan lacked to be revised to include treatment or therapy services of Rooke vascular boot and discontinuation of right lower leg brace. In addition, the plan lacked documentation of specific resident instructions for application of black compression wraps and Rooke vascular boot, including procedures for staff to notify the registered nurse (RN) when a problem arises for the application of Rooke vascular boots as indicated on R1's treatment management plan.

R3
R3's Elder Service Agreement dated May 10, 2022, lacked documented evidence of providing the treatment service of mechanical soft diet.

R3's Uniform Assessment Tool dated May 24, 2022, identified for "indicate any concerns that may affect the elder's ability to eat or drink: altered swallowing": did have a swallow evaluation and recommended nectar thick liquids, but refused to comply and was discontinued. Diet Texture of Mechanical Soft.

On June 1, 2022, at 9:15 a.m., the surveyor observed R3 in bed resting. R3 stated, "I need meats cut up".

R3's MAR dated May 2022, indicated "Diet: mechanical Soft".

R3's record identified a physician order dated September 9, 2019, for mechanical soft diet; however, lacked evidence of a current physician

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01940	Continued From page 74 order for the treatment service of mechanical soft diet. R3's Treatment /Therapy Management Plan dated April 4, 2022, indicated the "treatments/services provided/delegated to ULP" included "specialty diet (describe): mechanical soft". Documentation: specific elder instructions related to administration of treatments/therapy is located: on the elder's treatment administration record (TAR); in electronic health records (eTAR), service tasks. Staff will notify a licensed nurse or appropriate licensed health professional when a problem arises with treatment/therapy management services, including refusals and potential treatment inaccuracies. Specific parameters regarding treatments are also located: on the elder's treatment administration record (TAR); in electronic health records (eTAR) or service tasks. R3's Treatment/Therapy Management Plan lacked documentation of specific resident instructions and procedures for staff to notify the registered nurse (RN) when a problem arises for the treatment of mechanical soft diet as indicated on R3's treatment management plan. On June 2, 2022, at 12:27 p.m., registered nurse (RN)-B stated R1 "was using" Rooke boot. RN-B stated, "I will change brace", regarding not using. RN-B stated, "No" regarding having specific resident instructions for application of black compression wraps and Rooke vascular boot. RN-B confirmed R3's service agreement lacked the treatment service of specialty diet. RN-B stated R3 had a mechanical diet "when [R3] was admitted" to the facility and R3's record lacked a current "physician order" for "mechanical soft diet". RN-B confirmed R1 and R3's treatment	01940		

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01940	Continued From page 75 management plans lacked the above. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated July 20, 2021, indicated the RN may delegate to unlicensed personnel the administration of treatment or therapy if the unlicensed personnel if the RN has developed written, specific instruction for each client. The licensee's Delegation of Nursing Tasks 2.0 policy dated July 14, 2021, indicated when needed the RN would provide written specific instructions for performing the procedure to the ULP. The licensee's Delegation of Nursing Tasks 4.0 dated July 20, 2021, indicated treatment or therapy tasks may be delegated by a licensed health professional to unlicensed personnel and the RN "must" develop written specific instructions for each resident and document those instructions in the resident's record. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated July 19, 2021, indicated the RN would document the services the client would receive on the client's individualized treatment and therapy plan and the client's medication/treatment record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy	01950		

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01950	Continued From page 76 Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records for two of three residents (R1, R3) receiving treatments or therapy and had instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident and the ULP had demonstrated the ability to competently follow the procedures for two of two employees (ULP-F, ULP-G) with records reviewed. This practice resulted in a level two violation (a	01950		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 77	01950		

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:

R1
R1's Elder Service Agreement dated May 24, 2022, indicated R1 received assistance by staff to put on left leg wrap every day. R1's service agreement lacked documented evidence for the service of applying and removal of Rooke vascular boot (treats and prevents lower extremity skin breakdown).

On June 1, 2022, at 7:12 a.m., unlicensed personnel (ULP)-F stated the night shift assisted with putting a compression wrap on R1's left leg and if the wrap was not on R1's "leg would swell really bad". ULP-F stated R1 had a cast removed recently from her right leg and was unable to wear the compression wrap on her right leg due to swelling.

On June 1, 2022, at 8:55 a.m., the surveyor observed R1 have a black compression wrap with velcro straps on left leg. R1 stated she had a "cast" on her right leg and now had a "splint on at all times". R1 stated she had foot surgery. R1 stated staff "put wraps on and off" on her legs, the overnight person puts on the wraps and the evening person takes the wraps off".

R1's Medication Administration Record (MAR) dated May 2022 and Service Delivery Record

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	34568	A. BUILDING: _____ B. WING _____	06/03/2022

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BRIDGEWATER AT MANKATO	630 REED STREET MANKATO, MN 56001

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01950	Continued From page 78 dated May 2022, identified staff were signing for the treatment and therapy administration of compression wraps on in a.m. and off at bedtime and Rooke vascular boot to right lower extremity at bedtime and remove in morning. R1's Physician Order Sheet dated May 12, 2022, included orders for compression wraps to lower extremities and Rooke vascular boot. R1's Treatment/Therapy Management Plan was dated February 14, 2022. The plan indicated treatment/services provided were "compression garments"; however lacked the treatment service of Rooke boot vascular and Documentation: specific elder instructions related to administration of treatments/therapy is located: on the treatment administration record (TAR); in electronic health records (eTAR) or service tasks. Staff will notify a licensed nurse or appropriate licensed health professional when a problem arises with treatment/therapy management services, including refusals and potential treatment inaccuracies. Specific parameters regarding treatments are also located: on the elder's treatment administration record (TAR); in electronic health records (eTAR) or service tasks. R1's record lacked documentation of specific resident instructions for application of black compression wraps and Rooke vascular boot. R3 R3's Elder Service Agreement dated May 10, 2022, lacked documented evidence of providing the treatment service of mechanical soft diet. R3's Uniform Assessment Tool dated May 24, 2022, identified for "indicate any concerns that may affect the elder's ability to eat or drink:	01950		

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	34568	A. BUILDING: _____ B. WING _____	06/03/2022

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BRIDGEWATER AT MANKATO	630 REED STREET MANKATO, MN 56001

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01950	Continued From page 79	01950		

altered swallowing": did have a swallow evaluation and recommended nectar thick liquids, but refused to comply and was discontinued. Diet Texture of Mechanical Soft.

On June 1, 2022, at 9:15 a.m., the surveyor observed R3 in bed resting. R3 stated, "I need meats cut up".

R3's MAR dated May 2022, indicated "Diet: mechanical Soft".

R3's record identified a physician order dated September 9, 2019, for mechanical soft diet; however, lacked evidence of a current physician order for the treatment service of mechanical soft diet.

R3's Treatment /Therapy Management Plan dated April 4, 2022, indicated the "treatments/services provided/delegated to ULP" included "specialty diet (describe): mechanical soft". Documentation: specific elder instructions related to administration of treatments/therapy is located: on the elder's treatment administration record (TAR); in electronic health records (eTAR), service tasks. Staff will notify a licensed nurse or appropriate licensed health professional when a problem arises with treatment/therapy management services, including refusals and potential treatment inaccuracies. Specific parameters regarding treatments are also located: on the elder's treatment administration record (TAR); in electronic health records (eTAR) or service tasks.

R3's record lacked documentation of specific resident instructions for the treatment of mechanical soft diet.

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01950	Continued From page 80 ULP-F had a hire date of April 7, 2022. ULP-F's record lacked evidence of training and competency for the treatment of black compression wraps and Rooke vascular boot for R1 and mechanical soft diet for R3. ULP-G had a hire date of May 4, 2021. ULP-G's record lacked evidence of training and competency for the treatment of black compression wraps and Rooke vascular boot for R1 and mechanical soft diet for R3. On June 2, 2022, at 12:27 p.m., registered nurse (RN)-B stated R1 "was using" Rooke boot. RN-B stated, "No" regarding having specific resident instructions for application of black compression wraps and Rooke vascular boot for R1 and for R3 mechanical soft diet. RN-B confirmed R3's service agreement lacked the treatment service of specialty diet. RN-B stated R3 had a mechanical diet "when [R3] was admitted" to the facility. RN-B stated staff had been trained on diets. RN-B stated she had "gone over step by step verbally" with ULP-F and ULP-G for the treatments, but there was "no documentation". The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated July 20, 2021, indicated the RN may delegate to unlicensed personnel the administration of treatment or therapy if the unlicensed personnel if the RN has developed written, specific instruction for each client. Documentation of each unlicensed staff person's training and competency to assist or administer treatment or therapy would be retained in the personnel record of each staff person who has satisfied the above training and competency requirements.	01950		

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01950	Continued From page 81 The licensee's Delegation of Nursing Tasks 2.0 policy dated July 14, 2021, indicated when needed the RN would provide written specific instructions for performing the procedure to the ULP. The licensee's Delegation of Nursing Tasks 4.0 dated July 20, 2021, indicated treatment or therapy tasks may be delegated by a licensed health professional to unlicensed personnel and the RN "must" develop written specific instructions for each resident and document those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a prescribed treatment was documented accurately for one of	01960		

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01960	Continued From page 82 three residents (R1), with records reviewed. 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: R1's Physician Order Sheet dated May 12, 2022, included an order for right lower leg brace on a.m. and off at bedtime. On June 1, 2022, at 8:55 a.m., the surveyor observed R1 have a black compression wrap with velcro straps on left leg. R1 stated she had a "cast" on her right leg and now had a "splint on at all times". R1 stated she was "not using right leg brace" at this time. R1's Medication Administration Record (MAR) dated May 2022 and Service Delivery Record dated May 2022, identified staff were signing daily for the treatment and therapy administration of right lower leg brace on a.m. and off at bedtime. R1's record lacked accurate documentation for use of right lower leg brace. On June 2, 2022, at 12:27 p.m., registered nurse (RN)-B confirmed R1 was not utilizing the right leg brace. RN-B stated, "I will change brace", regarding not using. The licensee's Documentation of Medication,	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 83 Treatment and Therapy Management Services policy dated July 19, 2021, indicated staff would document the task immediately after that task has been performed. The policy did not address documentation for a task not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure prescriber orders for treatment or therapy for two of three residents (R1, R3) with records reviewed. 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).	01970		

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01970	Continued From page 84 The findings include: R1's Medication Administration Record (MAR) dated May 2022 and Service Delivery Record dated May 2022, identified staff were signing for the treatment and therapy administration of right lower leg brace on a.m. and off at bedtime and wound care-elevate and ice right foot 20 minutes every two hours while awake for five days. The first date of signature for the wound service was May 20, 2022, and signatures for administration of the service currently continued (past the five days). On June 1, 2022, at 7:12 a.m., unlicensed personnel (ULP)-F stated R1 had a cast removed recently from her right leg and was unable to wear the compression wrap on her right leg due to swelling. ULP-F stated, "We elevate and ice [R1's] right leg 20 minutes every two hours. On June 1, 2022, at 8:55 a.m., the surveyor observed R1 have a black compression wrap with velcro straps on left leg and a splint on right lower extremity. R1 stated she had a "cast" on her right leg and now had a "splint on at all times". R1 stated she had foot surgery. R1 stated staff "elevate her legs in a reclining chair and ice her right leg a couple times a day". R1 stated she was "not using right leg brace" at this time. R1's Physician Order Sheet dated May 12, 2022, included an order for right lower leg brace on a.m. and off at bedtime. R1's record lacked prescriber's orders for wound care-elevate and ice right foot 20 minutes every two hours while awake to continue past the five days and lacked an order for the discontinuation	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 85 of the treatment or hold the treatment for right lower leg brace. R3 R3's Uniform Assessment Tool dated May 24, 2022, identified for "indicate any concerns that may affect the elder's ability to eat or drink: altered swallowing": did have a swallow evaluation and recommended nectar thick liquids, but refused to comply and was discontinued. Diet Texture of Mechanical Soft. On June 1, 2022, at 9:15 a.m., the surveyor observed R3 in bed resting. R3 stated, "I need meats cut up". R3's MAR dated May 2022, indicated "Diet: mechanical Soft". R3's record identified a physician order dated September 9, 2019, for mechanical soft diet; however, lacked evidence of a current physician order for the treatment service of mechanical soft diet. On June 2, 2022, at 12:27 p.m., registered nurse (RN)-B stated, "I will change brace", for R1 regarding not using. RN-B stated regarding the elevation and ice treatment continuing past the prescriber's order for five days, "I would encourage it, because she gets swollen quite a bit". RN-B stated R1 had a "follow up ortho appointment today". RN-B stated R3 had a mechanical diet "when [R3] was admitted" to the facility and R3's record lacked a current "physician order" for "mechanical soft diet". The licensee's Renewal of Medication, Treatment or Therapy Prescriptions and Orders dated February 1, 2018, indicated a treatment or	01970		

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01970	Continued From page 86 therapy order must be current and must be renewed every 12 months or more frequently as indicated by the assessment of the elder by the nurse or the licensed health professional. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *05/31/22*
Time: 12:00:30
Report: 1028221103

Food and Beverage Establishment Inspection Report

Location:
Bridgewater at Mankato
Bridgewater at Mankato
630 Reed Street
Mankato, MN56001
Blue Earth County, 07

Establishment Info:
ID #: 0006411
Risk: Low
Announced Inspection: No

License Categories:
FBLB, FBC2, HOSP

Expires on: 12/31/22

Operator:
Bridge Water at Mankato LLC

Phone #: 5073814600
ID #: 51279

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonia: = at 200 Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Turkey
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Cheese
Violation Issued: No

Type: Full
Date: *05/31/22*
Time: 12:00:30
Report: 1028221103
Bridgewater at Mankato

Food and Beverage Establishment Inspection Report

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

This Inspection was conducted in conjunction with HRD.

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221103 of 05/31/22.

Certified Food Protection Manager: Taya Rux

Certification Number: FM107189 Expires: 07/20/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Taya Rux
Kitchen Manager

Signed: _____
Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us