Electronically Delivered

June 13, 2022

Administrator
South View Living Center
555 East 12th Street
Gibbon, MN 55335

RE: Project Number(s) SL30299015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 18, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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 St. Paul, MN 55164-0970

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

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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: SL30299015-0 On May 16, 2022, through May 18, 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 twelve (12) residents, all of whom received services under the provider's Assisted Living with Dementia Care 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to 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) and was issued at a	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 470	Continued From page 2	0 470		

widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

The licensee held an assisted living facility with dementia care license. The facility was licensed for a bed capacity of 12 and had a current census of 12 residents.

During the entrance conference on May 16, 2022, at approximately 10:45 a.m., licensed assisted living director (LALD)-A stated they developed a staffing plan and referred to their staffing plan policy/procedure.

The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy, dated December 17, 2021, indicated: direct-care staff would respond to resident requests within a reasonable amount of time between 10:00 p.m. and 6:00 a.m.; have a minimum of two staff scheduled at all times whenever a resident required the assistance of two; and have a registered nurse (RN) available at all times, either in person, via phone or other electronic method.

The licensee lacked a documented staffing plan that addressed residents' needs as identified in assessments and acuity level; indicated if it has a secured dementia unit; and addressed staff competency and training.

On May 18, 2022, at approximately 9:06 a.m., LALD-A stated she felt the staff schedule, along with the policy, was the staffing plan, adding she may have misread the intent of the statute. LALD-A stated they completed ongoing resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 470	Continued From page 3 assessments to determine needs and deploy numbers of staff based on that. LALD-A said at the time, two (unlicensed) staff worked each shift, in addition to the nurse, but has at times added "a floater" when they have had higher falls risks and acuity. LALD-A said she did not have any spreadsheet with numbers or have something written down, other than the policy, to know what was needed for staff. However, LALD-A expressed understanding of the requirement for a written staffing plan and said there was a way to quantify needs, such as the number of Hoyer (full-body) lifts and two-person transfers required. LALD-A said they were thinking of doing this for their "QA" (quality assurance) and "we can come up with something." The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy, referenced above, indicated: The organization will have an implemented, written staffing plan. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 4 fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure they did not require a resident to include and pay for meals in their assisted living contract for two of two residents (R1, R2) with records reviewed. Also, the license failed to ensure the food menu was available to all residents at least a week in advance. In addition, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CONTRACT INCLUDED MEALS REQUIREMENT R1's Resident Agreement for Assisted Living was signed by the resident's representative on November 3, 2021. R2's Resident Agreement for Assisted Living was signed by the resident's representative on November 10, 2021.	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 5 R1's and R2's Resident Agreements for Assisted Living with Dementia Care indicated its services were all inclusive. With respect to meal plans, the licensee offered 3 meals plus snacks which were included in the monthly rent price. R1's and R2's contracts had no alternative options, therefore, required the residents to purchase meals. On May 18, 2022, at approximately 9:20 a.m., licensed assisted living director (LALD)-A stated they hired an attorney to help out regarding the contract language. Office manager (OM)-B and LALD-A said they were trying to come up with a formula in regard to cost of meals and change the language in the contract about the meals so that it met the statutory requirement. AVAILABILITY OF FOOD MENU On May 16, 2022, at approximately 11:10 a.m., following the entrance conference, LALD-A and the surveyor briefly toured the facility. The day's lunch menu was written on a white board on a wall in the dining area. The surveyor observed no additional menu. On May 17, 2022, at approximately 9:26 a.m., unlicensed personnel (ULP)-H stated only the daily menu was written and posted, not a weekly or monthly one. ULP-H went into the nursing office and found the licensee's planned, monthly menu, which was contained in a binder. During a subsequent interview on May 19, 2022, at approximately 9:18 a.m., LALD-A said they can print a menu for the month and provide it to residents along with the activity calendar, adding this would "be an easy one" to fix. FOOD PREPARED PER THE MINNESOTA FOOD CODE Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 18, 2022, for the specific Minnesota Food Code deficiencies. No additional information was provided.	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment 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 and interview, the licensee failed to post required information related to the licensee's grievance procedure, contact information for the Office of Ombudsman 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 550	Continued From page 7 The licensee lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of signage or posting of 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, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On May 16, 2022, at approximately 11:10 a.m., the surveyor conducted a brief facility tour with the licensed assisted living director. The surveyor observed the main common areas (dining and adjacent TV/days rooms, and two hallway areas encircling resident rooms) lacked required postings of the grievance procedure, Ombudsmen's contacts and information related to reporting suspected maltreatment to MAARC. On May 17, 2022, at approximately 9:23 a.m., LALD-A stated residents and family received education and acknowledgment of receipt of information regarding our grievance procedure and other advocacy contacts. LALD-A stated those contact numbers were in the nursing office and acknowledged the required disclosure and contact information noted above was not posted or available in the public areas as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 680	Continued From page 8	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to affect all residents receiving services under the assisted living with dementia care license, staff and visitors to the facility.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 680	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 16, 2022, 10:43 a.m., the surveyor requested the licensee's emergency preparedness (EP) plan, including hazard assessments, policies and communication plan. Licensed assisted living director (LALD)-A stated there was a plan, but did not know if there was one document that included everything requested. LALD-A provided a number of documents and policies from a three-ringed binder. At approximately 11:10 a.m., the surveyor toured the facility with LALD-A and observed posted near the main entry a disclosure of the licensee's emergency preparedness plan, and numerous poster-sized diagrams of emergency exits on numerous walls in the building. There were also similar exit diagrams posted inside resident rooms. The licensee's plan included: a main policy; missing resident and weather emergencies policies/procedures; evacuation and relocation plan/procedures; fire emergency procedures; a resident tracking log; and a Hazard and Vulnerability Assessment Tool and summary. The licensee's plan lacked the following required	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 680	Continued From page 10 content: -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -development of all policies/procedures, based on assessment; and additional policies for: -process for EP collaboration with local, tribal, State and Federal EP; -policies & procedures for handling medical documents; -subsistence needs for staff and patents and sheltering in place; -medical documents; -use of volunteers; -roles under a waiver declared by the Secretary; -development of a communication plan, including: -primary and alternate means for communication; -names and contact information; -emergency officials contact information; -methods for sharing information; -sharing information on occupancy needs; -long term care family notifications; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On May 18, 2022, at approximately 11:37 a.m., LALD-A stated their plan needed more specifics. LALD-A commented "Appendix Z" (the state adopted emergency plan guidance) was overwhelming but added they could make changes to be compliant. The licensee's Emergency and Disaster Preparedness policy, dated December 23, 2021, reviewed July 28, 2021, referenced the current	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 680	Continued From page 11 assisted living statutes and rules, and indicated the facility would be prepared to manage emergency and disaster situations, including missing residents, through their hazard assessment and emergency planning. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 810	Continued From page 12 least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 16, 2022, at approximately 1:40 p.m. with Licensed Assisted Living Director (LALD)-A, Registered Nurse (RN)-B, and Owner/ Manager (OM)-G on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 810	Continued From page 13 protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-A indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, LALD-A indicated that a portion of the residents are capable of self-evacuation and that the fire safety and evacuation plan for the facility lacked these provisions. A policy on resident training for fire safety and evacuation was requested but one was not able to be provided. Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. During interview, LALD-A stated that licensee has not conducted evacuation drills for the employees to date at the time of survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 940 SS=C	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 940	Continued From page 14 (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with required content for two of two residents (R1, R2) with records reviewed. This had the potential to affect all residents of the facility. 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	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 940	Continued From page 15 affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Resident Agreement for Assisted Living was signed by the resident's representative on November 3, 2021. R2's Resident Agreement for Assisted Living was signed by the resident's representative on November 10, 2021. R1's and R2's Resident Agreements for Assisted Living with Dementia Care contracts lacked the following required content: A description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a statement that residents may be eligible for	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 940	Continued From page 16 assistance with rent through the housing support program; and -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On May 18, 2022, licensed assisted living director (LALD)-A and office manager (OM)-B said they were aware of the missing elements in the contract regarding the language around public assistance. OM-B said they used the same template for all resident contracts. LALD-A stated the licensee hired an attorney to help with the contract to address the issue. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 970	Continued From page 17 property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Following the entrance conference on May 16, 2022, 11:15 a.m., the licensee provided a current copy of the facility's assisted living contract as presented in an admission packet. The assisted living contract included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Page 14, section 27 titled "Liability of Resident and South View Living Center" indicated: South View Living Center is not responsible for any damage or injury that is done to Resident or his/her property, guests or their property that was not caused by south View living Center, its employees or agents. South View Living Center recommends that Resident obtain Renter's Insurance to protect against potential injures or property damage. The section titled "Acts of Third Parties" indicated: South View Living Center is not responsible for the actions, or for any damages, injury or harm caused by third parties (such as other residents, guests, intruders or trespassers) who are not under South View Living Center's control. On May 18, 2022, licensed assisted living director	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
0 970	Continued From page 18 (LALD)-A confirmed the assisted living contract contained clauses that required residents to waive the facility's liability for health, safety, or personal property. LALD-A said all residents in the facility signed the same assisted living contract. LALD-A stated she was aware of the issue regarding facility liability and expressed frustration regarding the citation, adding it was difficult for smaller providers, who have limited resources, and trusted others to interpret what the State required in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
01910	Continued From page 19 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the medical record regarding disposition of medication for one of one discharged resident (R3) 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: R3's Service Plan dated June 16, 2021, indicated R3 received medication administration services daily. R3's medical record indicated the resident discharged from the facility on October 26, 2021, to a different assisted living facility. R3's discharge summary progress note, dated October 26, 2021, indicated the faciltiy discharged R3 to another facility closer to family. The note indicated the licensee sent all medications with R3, including new refills for November, along with the current medication administration record and progress notes. R3's record lacked documentation of medication disposition with all required information, including	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
01910	Continued From page 20 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 16, 2022, at approximately 3:39 p.m., licensed assisted living director (LALD)-A acknowledged R2's discharge paperwork had no record of the specific pills and quantity that were sent when the resident was discharged. LALD-A said they would address the concern. The licensee's Disposition or Disposal of Medication policy, dated December 20, 2021, indicated a resident's current medications secured or stored by the facility would be given to the resident or the resident's representative when the resident's medications services are terminated. Further, staff would document in the resident's record the name of the person to whom the medications were given, the time and date, and the name of each medication and the amount of medication remaining. The policy did not indicate inclusion of the medication's strength in the disposition information, as required by the statute. The policy indicated staff would document the disposition or disposal of medication in the resident's record. No further information was provided. Time period for correction: Twenty-one (21) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
02040	Continued From page 21 requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 16, 2022, at approximately 1:40 p.m. with Licensed Assisted Living Director (LALD)-A, Registered Nurse (RN)-B, and Owner/ Manager (OM)-G on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
02040	Continued From page 22 indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-A stated that licensee had conducted a hazard vulnerability assessment for the emergency disaster plan for the facility but had not conducted a hazard vulnerability assessment of the physical environment with mitigation factors on and around the property to date at the time of survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 23 how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents legal and designated representatives at the time of move-in for two of two residents (R1, R2) with records reviewed. This had potential to affect all residents, families and prospective residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: During the entrance conference on May 16, 2022, at approximately 10:20 a.m., licensed assisted living director (LALD)-A stated they were licensed	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 24 as an assisted living facility with dementia care. R1 was admitted for services October 29, 2021. R1's service plan, dated November 3, 2022, indicated services included medication and treatment management, dressing assistance, daily meals and snacks, housekeeping, linens, laundry and push-button response system. R2 was admitted for services November 28, 2017. R2's service plan, dated November 10, 2022, indicated services included medication management, assistance with activities of daily living, daily meals and snacks, mobility assistance, housekeeping, linens, laundry and push-button response system. R1's and R2's records lacked evidence the required dementia-care policies and procedures were provided to each resident and/or the resident's legal and designated representative. On May 17, 2022, at approximately 10:39 a.m., LALD-A stated they understood the dementia-care policies were addressed and covered with the "dementia training disclosure" provided to residents and families upon admission. LALD-A said she did not know the specific policies had to be provided to families. LALD-A indicated the policies were available to the resident's and/or representatives, which were located in a notebook/binder, but the policies were not provided to each resident and/or representative at the time of move-in. The licensee's Philosophy of Service Provision - Mission, Values, Person-centered Care policy, dated December 27, 2021, included required policies for provision of dementia care. The policy lacked mention of or procedures how these	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 25 policies were distributed to each resident and/or representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02320 SS=F	144G.91 Subd. 4 Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered in accordance with accepted standards for 6 of 6 residents (R4, R5, R6, R8, R9 and R10) whose medications were set up by unlicensed personnel ahead of time for later administration. This had potential to affect all current residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
02320	Continued From page 26 R4 R4's diagnoses included hypomagnesemia, chronic kidney disease, anemia, vascular dementia, vitamin D deficiency and hypertension. R4's Service and Medication Management plans, both dated November 1, 2021, indicated the resident received medication management services. R4's prescriber's orders, dated November 1, 2021, included medications for: blood pressure, allergies, depression, dementia, mood stabilization, acid reflux, cholesterol, pain and dietary supplements. R5 R5's diagnoses included respiratory failure, dementia, hypertension, chronic kidney disease, hypothyroidism and hyperlipidemia. R5's Service Plan, dated November 22, 2021, and R5's Medication Management Plan, dated November 12, 2022, indicated the resident received medication management services. R5's prescriber's orders dated November 10, 2021, included medications for: memory loss, blood clot prevention, thyroid, blood pressure, acid reflux, fluid retention and pain. R6 R6's diagnoses included encephalopathy, ataxia (lack of muscle control and diminished coordination) and hypertension. R6's Service Plan and Medication Management Plan, each dated May 11, 2021, indicated the resident received medication management	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
02320	Continued From page 27 services. R6's prescriber's orders, dated October 29, 2021, included medications for pain, cholesterol, anxiety, shortness of breath and dietary supplements. R8 R8's diagnoses included malnutrition, failure to thrive and mood disorder. R8's Service Plan, dated November 12, 2021, indicated the resident received medication management services. R8's prescriber's orders, dated June 18, 2021, included medications for: sleep, mood, depression, seizures, pain, dietary supplements and vitamins. R9 R9's diagnoses included hypotension, brain tumor, insomnia, anemia, anxiety disorder, seizure disorder and hydrocephalus. R9's Service Plan, dated January 17, 2021, and Medication Management Plan, dated January 12, 2022, each indicated the resident received medication management services. R9's prescriber's orders dated May 18, 2022, included medications for: mood, brain stimulation, seizures, immune support, anxiety, pain, vitamins. R10 R10's diagnoses included lipidemia, osteoarthritis, diabetes, hypertension and chronic obstructive pulmonary disorder.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
02320	Continued From page 28 R10's Service Plan, dated January 19, 2022, indicated the resident received medication management services. R10's prescriber's orders, dated July 6, 2021, included medications for pain, stroke prevention, sleep, blood pressure, depression and vitamins. On May 16, 2022, at approximately 2:38 p.m., unlicensed personnel (ULP)-E told the surveyor she was going to "set up 5 p.m. meds" (medications) for residents. ULP-E stated she was setting them up right now and would pass them "at 5 o'clock." ULP-E was at the medication cart and retrieved medications for R6, some in pharmacy-prepared bubble packages and some in pill bottles. ULP-E compared the label on the medication to the medication administration record (MAR) in the computer and dispensed a total of 6 pills into a small plastic medication cup. ULP-E then wrote R5's name and the number "5" on the outside bottom of a paper medication cup and placed it over the medications in the plastic cup, then placed that into a compartment in the medication cart. Following the same procedures, ULP-E completed the task for six other residents, including: R5, R6, R8, R9 and R10. ULP-E stated this was her usual routine, setting up "the 5 p.m. medications" now (at around 3 p.m.). ULP-E verified she was going to administer the medications for the residents later. ULP-E stated she liked to set the pills up at the beginning of the shift because later, there was supper, and residents needed to be toileted, and "it gets really busy." ULP-E added she did not	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
02320	Continued From page 29	02320		

think it was an issue of staffing, but rather because there was much to do at that time and was easier to set the meds up ahead of time.

Later, at approximately 3:16 p.m., licensed assisted living director (LALD)-A talked with the surveyor about the ULP setting up medications ahead of time for later administration and acknowledged it was a practice that had been in place for some time. LALD-A stated the evening shift was "busier" and this was the practice followed. LALD-A stated on other shifts, medications were set up and passed "in real time" and that narcotics were never set up that way, as there was a protocol to monitor and count those medications. LALD-A said she did not think it was done because of staffing levels. LALD-A stated the current resident acuity level was "low," but in the past had scheduled a "floater" staff to assist at times, for example when they've had residents with higher fall risks, behaviors or other needs. LALD-A stated she was not rationalizing the practice but stated the facilitiy had not been surveyed in over seven and one-half years, adding they would "change the workflow."

The surveyor reviewed medication error reports from November 2021 through May 2022. There were no incidents of staff administering medications to the wrong resident.

Review of ULP-E's employee training record indicated the ULP passed a medication skill competency on March 9, 2022. The procedure for administration of oral medications directed, following safety checks, medications were to be given, then documented.

On May 18, 2022, at approximately 8:08 a.m., registered nurse (RN)-B stated they were ware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30299	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VIEW LIVING CENTER	555 EAST 12TH STREET GIBBON, MN 55335

(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
02320	Continued From page 30 the p.m. (evening) shift had been setting up medications ahead of time, and said "I suppose" it's due to staff's work duties around the meal time. RN-B stated it was a not a practice taught in nursing and staff should be administering one resident's medications at a time. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy, dated December 20, 2022, indicated medications were to always be administered according to the "6 Rights," which included the Right Time. The policy did not address setting up medications ahead of time for later administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

DEPARTMENT OF HEALTH

Type: Full
Date: *05/18/22*
Time: 10:00:59
Report: 1033221035

Food and Beverage Establishment Inspection Report

Location:
Southview Living Center
555 East 12th Street
Gibbon, MN55335
Sibley County, 72

Establishment Info:
ID #: 0017620
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
J.A.M., Inc.

Phone #: 5078346510
ID #: 42064

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

The following orders were issued during this inspection.

3-200A Food Characteristics: approved source

3-201.11B ** Priority 1 **

MN Rule 4626.0130B Remove all foods that were prepared or stored in a private home from the premises, except as allowed in Minnesota Statutes 28A.15 and 157.22 clauses 6 and 7.

Facility had one jar of canned peaches made in a private residence.

Comply By: 05/18/22

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

Chlorine was measured at 200ppm in spray bottle.

Comply By: 05/18/22

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

Facility does not have a small diameter probe.

Comply By: 06/01/22

Type: Full
Date: *05/18/22*
Time: 10:00:59
Report: 1033221035
Southview Living Center

Food and Beverage Establishment Inspection Report

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Facility uses crock pots that are not allowed for hot holding.

Comply By: 05/18/22

Surface and Equipment Sanitizers

Hot Water: = at 180.5 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Chlorine: = 200 at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Pears-Two Door Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: Noodle Salad-Two Door Cooler
Violation Issued: No

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

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

I acknowledge receipt of the inspection report number 1033221035 of 05/18/22.

Certified Food Protection Manager: Jason Melby

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Jason Melby
Owner

Signed: 

Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us