DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

November 22, 2022

Administrator
Mother Of Mercy Senior Living
230 Church Avenue
Albany, MN 56307

RE: Project Number(s) SL30461015

Dear Administrator:

On November 3, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 15, 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
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

Electronically Delivered

October 5, 2022

Administrator
Mother Of Mercy Senior Living
230 Church Avenue
Albany, MN 56307

RE: Project Number(s) SL30461015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 15, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**
**St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00**

**The total amount you are assessed is $3,500.00**. 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:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

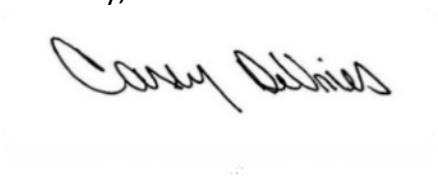
**REQUESTING A HEARING**

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,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
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Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30461 | A. BUILDING: _____ B. WING _____ | 09/15/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOTHER OF MERCY SENIOR LIVING | 230 CHURCH AVENUE ALBANY, MN 56307 |

| (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 |
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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL30461015-0<br><br>On September 12, 2022, through September 15, 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 47 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.<br><br>An immediate correction order was issued on September 14, 2022, for SL30461015-0, tag identification 2310.<br><br>On September 15, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a level 3, scope of widespread violation. | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(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:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all 47 residents residing at the facility.<br><br>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).<br><br>The findings include:<br><br>Please refer to the additional documentation | 0 480 | | |

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| 0 480 | Continued From page 2<br>included in the Food and Beverage Establishment Inspection Reports, dated September 12, 2022.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This deficient practice had the potential to affect the licensee's 47 current residents, staff and visitors.<br><br>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 | 0 510 | | |

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| 0 510 | Continued From page 3<br>or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>PERSONAL PROTECTIVE EQUIPMENT (PPE)<br><br>On September 12, 2022, at approximately 10:05 a.m., upon entering the facility, unlicensed personnel (ULP)-L and ULP-M greeted the surveyors in the common area of Grace Court, where the surveyors observed the staff to be wearing medical-grade facemasks, but no eye protection.<br><br>On September 12, 2022, at approximately 12:15 p.m., the surveyor observed an unidentified staff pushing a cart near residents through the hallway, into the serving kitchen in Fairway Ridge, wearing a medical-grade mask, but no eye protection.<br><br>On September 12, 2022, at approximately 2:15 p.m., an unidentified female in light green scrubs and carrying a bag, walked through the hallway in Fairway Ridge, and encountered a resident that asked a question. The unidentified female stood directly next to the resident, called her by name and visited with the resident for a few minutes. The unidentified female wore a medical-grade mask; however, no eye protection. At 2:40 p.m., the surveyor interviewed the unidentified female, who identified herself as a hospice registered nurse (RN), from a visiting hospice agency. When asked if she was directed to wear eye protection while in the facility, she stated she had goggles in her car, but she typically did what the staff in the facility did, and the facility staff at this facility didn't wear eye protection. The hospice RN stated she was never told by anyone that she should be wearing eye protection while visiting the | 0 510 | | |

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| 0 510 | Continued From page 4<br>licensee's residents, so she hadn't been wearing them.<br><br>During an interview on September 12, 2022, at approximately 2:55 p.m., licensed practical nurse (LPN)-B stated the staff were told they needed to wear medical-grade masks and eye protection, but stated she didn't know if they were routinely wearing eye protection, and didn't know whose responsibility it was to ensure staff were wearing eye protection. LPN-B stated she reminded staff to wear eye protection when she encountered staff without it. LPN-B stated all staff entered through the main entrance and were screened electronically for COVID symptoms, but stated she wasn't sure if anyone reminded them to wear the appropriate PPE.<br><br>On September 13, 2022, at approximately 12:10 p.m., licensed assisted living director (LALD)-C stated staff were required to wear masks and eye protection and were reminded often; however, verified not all staff were wearing eye protection when the surveyors entered the facility on September 12, 2022. The surveyor showed LALD-C where to find PPE requirements according to the community transmission rate on the Centers for Disease Control and Prevention website, which showed the community transmission rate in Stearns County was "high" indicating eye protection was required in congregate care settings when providing care to residents.<br><br>MDH guidance titled, "COVID-19 PPE and Source Control Grids - For Congregate Care Settings, by Community Transmission Level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the CDC online data tracking system), | 0 510 | | |

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| 0 510 | Continued From page 5<br>caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection.<br><br>The licensee's Coronavirus Disease 2019 Preventing Controlling the Transmission-Assisted Living policy, revised September 2022, directed all facility staff will don a mask throughout their time within the facility, except in designated break areas. Further, when the county transmission level is at substantial or high transmission, facility staff should wear eye protection (i.e., goggles or a face shield that covers the front and sides of the face) during all resident encounters.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by: | 0 550 | | |

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| 0 550 | Continued From page 6<br><br>Based on observation and interview, the licensee failed to post the required information to include the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all current residents, staff and visitors.<br><br>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).<br><br>The findings include:<br><br>On September 12, 2022, at approximately 11:30 a.m., the surveyors toured the facility with licensed assisted living director (LALD)-C. The facility had a bulletin board near the staff desk which contained their grievance procedure, but lacked the required information to include the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities as required.<br><br>On September 12, 2022, at approximately 3:25 p.m., LALD-C confirmed the posting lacked the above required content.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 550 | | |
| 0 630 SS=D | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma | 0 630 | | |

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| 0 630 | Continued From page 7<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the resident's risk of abusing other vulnerable adults for one of four residents (R3).<br><br>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).<br><br>The findings include:<br><br>R3's diagnoses included diabetes, Parkinson's Disease, orthostatic hypotension (blood pressure decreases when standing), and diabetic polyneuropathy (peripheral nerve damage).<br><br>R3's Planned Services, identified as the | 0 630 | | |

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| 0 630 | Continued From page 8<br><br>licensee's service plan, as of September 13, 2022, indicated R3 received services which included assistance with dressing, oral care, and medication assistance; however, the service plan lacked a signature or authentication by the facility and the resident/resident's representative, documenting agreement on the services to be provided.<br><br>R3's Individual Abuse Prevention Plan (IAPP), dated June 27, 2022, indicated R3 was at risk to be abused with statements of the specific measures to be taken to minimize the risk of abuse, had no history of suicide or thoughts of suicide, and was not at risk to abuse himself. R3's IAPP identified he was at risk for falling; however, did not include statements of specific measures to be taken to minimize the fall risk. R3's assessment lacked a review of R3's risk of abusing other vulnerable adults, as required.<br><br>On September 14, 2022, at approximately 10:10 a.m., registered nurse (RN)-A verified R3's IAPP did not include the required information.<br><br>The licensee's Individual Abuse Prevention Plan policy, revised August 1, 2021, indicated the plan would contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults, the person's risk of abusing other vulnerable adults, and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |

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| 0 660 SS=E | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including evidence of a two-step tuberculin skin test (TST) or other evidence of a TB screening such as a blood test for three of four employees (registered nurse (RN)-A, licensed practical nurse (LPN)-B and unlicensed personnel (ULP)-H).<br><br>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 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 | 0 660 | | |

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| MOTHER OF MERCY SENIOR LIVING | 230 CHURCH AVENUE ALBANY, MN 56307 |

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| 0 660 | Continued From page 10<br>occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>The licensee's Facility Tuberculosis Risk Assessment dated September 8, 2022, identified the licensee was a low risk level.<br><br>RN-A<br>RN-A began providing assisted living services on August 5, 2022.<br><br>RN-A's employee record contained a Baseline TB Screening Tool for Health Care Workers (HCWs) form which indicated a first step TST was administered on August 9, 2022, and read on August 12, 2022. In addition, it noted a second step TST administered on September 14, 2022, at 2:05 p.m. The form instructed "If results are negative, perform the second step in one to three weeks."<br><br>LPN-B<br>LPN-B began providing assisted living services on July 1, 2022.<br><br>LPN-B's employee record contained a Baseline TB Screening Tool for Health Care Workers (HCWs) form which indicated a first step TST was administered on July 1, 2022, and read on July 3, 2022. In addition, it noted a second step TST administered on September 14, 2022 at 1:48 p.m. The form instructed "If results are negative, perform the second step in one to three weeks."<br><br>ULP-H<br>ULP-H began providing assisted living services on June 28, 2022. | 0 660 | | |

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| 0 660 | Continued From page 11<br><br>ULP-H's employee record contained a Baseline TB Screening Tool for Health Care Workers (HCWs) form which indicated a first step TST was administered on June 9, 2022, and read on June 12, 2022. The form instructed, "If results are negative, perform the second step in one to three weeks."<br><br>TB history and symptom screen and documentation of a TST read on June 12, 2022; however, it lacked evidence of a second TST, as required.<br><br>On September 14, 2022, at approximately 2:01 p.m., human resources personnel (HR)-I confirmed both RN-A and LPN-B had only received the first TST, and had gone to get the second step administered during the survey on September 14, 2022, which was noted on the documentation provided.<br><br>The licensee's Tuberculosis Screening policy dated August 2021 noted new staff would have a blood test or two-step TST conducted with results documented.<br><br>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." | 0 660 | | |

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| 0 660 | Continued From page 12<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing tenant residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review the licensee failed to prominently post the | 0 680 | | |

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| 0 680 | Continued From page 13<br>facility's emergency disaster plan. This had the potential to affect all 47 residents, staff and visitors of the licensee.<br><br>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).<br><br>Findings include:<br><br>On September 12, 2022, at approximately 11:32 a.m., during a tour of the facility with licensed assisted living director (LALD)-C, the surveyor observed there was no information regarding the licensee's disaster plan posted in a prominent area or elsewhere in the facility.<br><br>On September 15, 2022, at approximately 11:45 a.m., the administrator from the attached nursing home confirmed the emergency preparedness plan was not posted prominently, and stated the license would be placing the emergency preparedness plan in binders, in common areas throughout the facility.<br><br>The licensee's Disaster Planning and Emergency Preparedness, revised August 2021, indicated the licensee would develop a written emergency disaster plan that contained the required content; however, lacked direction to post the emergency plan prominently, as required.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One | 0 680 | | |

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| 0 680 | Continued From page 14<br>(21) days | 0 680 | | |
| 0 730 SS=D | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(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;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(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;<br>(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;<br>(11) documentation that services have been | 0 730 | | |

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| 0 730 | Continued From page 15<br>provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of one discharged resident (R5).<br><br>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).<br><br>The findings include:<br><br>R5's diagnoses included late onset Alzheimer's disease without behavioral disturbance.<br><br>R5 began receiving services on May 6, 2019, and was discharged on July 12, 2022.<br><br>R5's Planned Services identified as the service plan, as of September 19, 2022, indicated R5 received services including toileting, dressing, | 0 730 | | |

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| 0 730 | Continued From page 16<br>meals, mobility, escort assist, grooming, behavior monitoring, medication administration, laundry and housekeeping.<br><br>R5's record lacked evidence the licensee completed a discharge summary.<br><br>On September 13, 2022, at approximately 10:55 a.m., licensed assisted living director (LALD)-C verified there was no evidence of a discharge summary for R5.<br><br>The licensee's Resident Record - Information and Content policy, revised August 2021, indicated the resident record must include a discharge summary, including service termination notice and related documentation, when applicable.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days | 0 730 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but | 0 780 | | |

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| 0 780 | Continued From page 17<br>not including crawl spaces and unoccupied attics;<br>(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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff.<br><br>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:<br><br>On September 13, 2022, between 10:30 a.m. and 12:45 p.m., survey staff toured the facility with the director of maintenance (DM)-D and the regional clinical director (RCD)-E. During the facility tour, survey staff observed that smoke alarms were not installed in the sleeping rooms of apartments 108, 111, 112, 203, 206, 240, 244, 308, and 309 in the Fairway Ridge building. During the tour interview, the DM-D confirmed that some of the apartments did not have smoke alarms installed in the sleeping rooms. | 0 780 | | |

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| 0 780 | Continued From page 18<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff.<br><br>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:<br><br>On September 13, 2022, between 10:30 a.m. and 12:45 p.m., survey staff toured the facility with the director of maintenance (DM)-D and the regional clinical director (RCD)-E. During the facility tour, survey staff observed the following: | 0 800 | | |

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| 0 800 | Continued From page 19<br><br>1. Two deck floorboards were in disrepair on the Fairway Ridge building.<br>2. One section of the floor was duct taped in the public restroom located near the nurse station in the Fairway Ridge building. The toilet was also noted as soiled in this restroom.<br><br>The DM-D confirmed during the tour interview that the deck and restroom floor required repair and that the toilet required cleaning.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be | 0 810 | | |

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| 0 810 | Continued From page 20<br>readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, document review, and interview, the licensee failed to provide the required plans and employee training for fire safety and evacuation. This had the potential to directly affect all residents and staff.<br><br>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:<br><br>On September 13, 2022, between 10:30 a.m. and 12:45 p.m., survey staff toured the facility with the director of maintenance (DM)-D and the regional clinical director (RCD)-E. During the facility tour, survey staff observed that the evacuation maps posted on the first and third floors of the Fairway Ridge building and one map on the main floor of the Memory Lane building did not identify the location and number of resident sleeping rooms. | 0 810 | | |

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| 0 810 | Continued From page 21<br><br>In an interview with DM-D during the facility tour, they confirmed that this information was missing from some of the maps.<br><br>On September 13, 2022, at approximately 12:45 p.m., documents were provided by the regional clinical director (RCD)-E for review. Documents were reviewed by survey staff on September 13, 2022, between 12:45 p.m. and 1:45 p.m.<br>1. The fire safety and evacuation plans failed to include the identification of unique or unusual resident needs for movement or evacuation.<br>2. The licensee failed to provide the required employee training frequency. Employee training for fire safety and evacuation was completed upon hire and then annually but did not require training at least twice per year after hire.<br><br>On September 13, 2022, at approximately 1:50 p.m., the licensed assisted living director (LALD)-C confirmed during the exit interview that the fire safety and evacuation plans required additional information and that training for employees was needed at least twice per year after hire.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 900 SS=D | 144G.50 Subdivision 1 Contract required<br><br>(a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.<br><br>(b) The contract must contain all the terms | 0 900 | | |

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| 0 900 | Continued From page 22<br>concerning the provision of:<br>(1) housing;<br>(2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and<br>(3) the resident's service plan, if applicable.<br><br>(c) A facility must:<br>(1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and<br>(2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.<br><br>(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.<br><br>(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.<br><br>(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of four residents (R2) reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 900 | | |

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| MOTHER OF MERCY SENIOR LIVING | 230 CHURCH AVENUE ALBANY, MN 56307 |

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| 0 900 | Continued From page 23<br>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).<br><br>The findings include:<br><br>R2 was admitted on February 1, 2022, and received services under the licensee's assisted living with dementia care license.<br><br>R2's diagnoses included major depressive disorder, unresolved grief, psychosis (severe mental disorder with impaired thoughts and emotions), and suicidal ideation.<br><br>R2's Planned Services, intended as the service plan, dated as of September 13, 2022, indicated R2 received meals, vital sign monitoring, safety checks, medication set-up, and medication administration.<br><br>R2's record included a written contract which indicated R2's occupancy date was February 1, 2022; however, was not signed by R2 until February 10, 2022, nine days after he began receiving assisted living services, instead of prior to the licensee offering or providing housing or assisted living services, as required.<br><br>On September 15, 2022, at approximately 11:00 a.m., licensed assistant living director (LALD)-C indicated she didn't know why R2's contract was signed nine days after he moved in and began receiving assisted living services.<br><br>The licensee's Signing an Assisted Living | 0 900 | | |

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| 0 900 | Continued From page 24<br><br>Contract policy, revised August 2021, directed the assisted living contract would be reviewed with the prospective resident and/or responsible person and answer any questions they may have, and two copies would be signed, one for the resident and one would be retained in the resident's record. The policy lacked direction the licensee may not offer or provide housing or assisted living services unless a written contract has been executed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 900 | | |
| 0 970 SS=C | 144.50 Subd. 5 Waivers of liability prohibited<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety or personal property of a resident. This had the potential to affect all residents.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than | 0 970 | | |

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| 0 970 | Continued From page 25<br>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).<br><br>The findings include:<br><br>The licensee's assisted living contract included a section on page 16 titled "Liability" that noted "Landlord is not liable to Tenant or Tenant's guests for any injury, death or property damage occurring in the Apartment or on Landlord's premises unless such injury, death or property damage occurs as the result of Landlord's own negligent acts or those of its employees or agents. Landlord is also not liable for any injury, death or damage occurring as the result of Tenant's receipt of health-related, supportive or other services from third party providers. Unless caused by one of the aforementioned excepted reasons, Tenant agrees to hold Landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident tor other occurrence in the Apartment or on Landlord's premises".<br><br>On September 14, 2022, licensed assisted living director (LALD)-C stated she was not aware the regulation, and added the licensee was getting new contracts.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |

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| 01060 | Continued From page 26 | 01060 | | |
| 01060 SS=D | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and<br>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br>(d) Following an emergency relocation, a facility's | 01060 | | |

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| 01060 | Continued From page 27<br>refusal to provide housing or services constitutes a termination and triggers the termination process in this section.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of four residents (R4).<br><br>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).<br><br>The findings include:<br><br>R4's diagnoses included dementia.<br><br>R4's progress notes noted:<br>- July 13, 2022, R4 had a fall and was bleeding. "A hospice nurse had gone by [R4] as well as she was lying on the floor and gave direction for staff to call and have her sent in." R4's family member was notified and indicated the hospital she wished R4 to be sent to.<br>- July 14, 2022, licensed assisted living director (LALD)-C contacted R4's daughter for an update and was informed R4 had dislocated her shoulder and had to be sedated in order to get it back in place. In addition, the daughter stated they were anticipating R4 would require rehabilitation | 01060 | | |

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| 01060 | Continued From page 28 | 01060 | | |

services after discharge. R4 sustained a laceration on her forehead which was addressed with glue at the hospital.
- July 15, 2022, LALD-C noted R4 had been admitted to the hospital for observation and required rehabilitation before returning to the assisted living, and planned to be admitted to the skilled nursing facility attached to her assisted living facility on this date.
- July 28, 2022, a care conference note indicated the goal was to get R4 back to baseline or as close as possible, before returning to the assisted living.
- September 9, 2022, order received to discharge to the assisted living on current medications and treatments, including therapy.

R4's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R4 received services including assistance with oral cares and toileting, behavior monitoring, and medication administration.

R4's record lacked evidence of a written notice provided to the resident, the resident's legal representative, and designated representative that contained, at a minimum:
- the reason for the relocation;
- the name and contact information for the location to which the resident has been relocated and any new service provider;
- contact information for the OOLTC;
- if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and
- a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact

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| 01060 | Continued From page 29<br>information for the agency to which the resident may submit an appeal.<br><br>In addition, R4's record lacked notification to the OOLTC that R4 had been relocated and had not returned to the facility within four days.<br><br>On September 14, 2022, at approximately 9:40 a.m., registered nurse (RN)-A and licensed practical nurse (LPN)-B stated they were not aware of the need to provide the notice, and did not see one in R4's chart.<br><br>The licensee's Emergency Relocation policy dated September 2022, noted in the event of an emergency relocation, the licensee would provide written notice to include:<br>- the reason for the relocation;<br>- the name and contact information for the location to which the resident has been relocated and any new service provider;<br>- contact information for the OOLTC;<br>- if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>- a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>In addition, the policy noted the notice would be delivered to the OOLTC if the resident had been relocated and had not returned to the facility within four days.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One | 01060 | | |

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| 01060 | Continued From page 30<br>(21) days | 01060 | | |
| 01370 SS=E | 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn<br><br>(a) Training and competency evaluations for all unlicensed personnel must include the following:<br>(1) documentation requirements for all services provided;<br>(2) reports of changes in the resident's condition to the supervisor designated by the facility;<br>(3) basic infection control, including blood-borne pathogens;<br>(4) maintenance of a clean and safe environment;<br>(5) appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>(6) training on the prevention of falls;<br>(7) standby assistance techniques and how to perform them;<br>(8) medication, exercise, and treatment reminders;<br>(9) basic nutrition, meal preparation, food safety, and assistance with eating;<br>(10) preparation of modified diets as ordered by a licensed health professional;<br>(11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;<br>(12) awareness of confidentiality and privacy;<br>(13) understanding appropriate boundaries between staff and residents and the resident's | 01370 | | |

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| 01370 | Continued From page 31<br>family;<br>(14) procedures to use in handling various emergency situations; and<br>(15) awareness of commonly used health technology equipment and assistive devices.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for three of three unlicensed personnel ((ULP)-F, ULP-G and ULP-H).<br><br>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 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).<br><br>The findings include:<br><br>ULP-F<br>ULP-F started employment on July 28, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021.<br><br>On September 13, 2022, from approximately 8:29 a.m. through 8:48 a.m., the surveyor observed ULP-F administer medications to residents in the memory care unit.<br><br>ULP-F's employee record lacked documented evidence to indicate the employee completed | 01370 | | |

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| 01370 | Continued From page 32<br>training and/or practical skills evaluations as required in the following areas:<br>- medication, exercise, and treatment reminders; and<br>- awareness of commonly used health technology equipment and assistive devices.<br><br>On September 14, 2022, at approximately 9:05 a.m., licensed assisted living director (LALD)-C confirmed she was unable to provide documented evidence of the above required training.<br><br>ULP-G<br>ULP-G began providing assisted living services on May 16, 2022.<br><br>On September 14, 2022, at approximately 7:00 a.m., the surveyor observed ULP-G administer insulin to R11 in his apartment.<br><br>ULP-G's employee record lacked documented evidence to indicate the employee completed training and/or practical skills evaluations as required in the following areas:<br>- maintenance of a clean and safe environment;<br>- hair care and bathing;<br>- care of teeth, gums, and oral prosthetic devices;<br>- care and use of hearing aids;<br>- dressing and assisting with toileting;<br>- standby assistance techniques and how to perform them; and<br>- awareness of commonly used health technology equipment and assistive devices.<br><br>ULP- H<br>ULP-H began providing assisted living services on June 28, 2022.<br><br>ULP-H's employee record lacked documented | 01370 | | |

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| 01370 | Continued From page 33<br>evidence to indicate the employee completed training and/or practical skills evaluations as required in the following areas:<br>- maintenance of a clean and safe environment;<br>- hair care and bathing;<br>- care of teeth, gums, and oral prosthetic devices;<br>- care and use of hearing aids;<br>- dressing and assisting with toileting;<br>- standby assistance techniques and how to perform them;<br>- medication, exercise, and treatment reminders;<br>- communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and<br>- awareness of commonly used health technology equipment and assistive devices.<br><br>On September 14, 2022, at approximately 9:27 a.m., LALD-C confirmed she was unable to provide documented evidence of the above required training.<br><br>The licensee's Competency Training Evaluations policy, revised August 2021, indicated a registered nurse would determine what nursing services may be delegated to properly trained and competency tested ULP. Training and competency evaluations for all ULP would include the required content.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 01370 | | |
| 01380 SS=E | 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn | 01380 | | |

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| 01380 | Continued From page 34<br><br>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:<br>(1) observing, reporting, and documenting resident status;<br>(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;<br>(3) reading and recording temperature, pulse, and respirations of the resident;<br>(4) recognizing physical, emotional, cognitive, and developmental needs of the resident;<br>(5) safe transfer techniques and ambulation;<br>(6) range of motioning and positioning; and<br>(7) administering medications or treatments as required.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for three of three unlicensed personnel ((ULP)-F, ULP-G and ULP-H).<br><br>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 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).<br><br>The findings include:<br><br>ULP-F | 01380 | | |

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| 01380 | Continued From page 35<br><br>ULP-F started employment on July 28, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021.<br><br>On September 13, 2022, from approximately 8:29 a.m. through 8:48 a.m., the surveyor observed ULP-F administer medications to residents in the memory care unit.<br><br>ULP-F's employee record lacked documented evidence to indicate the employee completed training and/or practical skills evaluations as required in the following areas:<br>- recognizing physical, emotional, cognitive, and developmental needs of the resident.<br><br>On September 14, 2022, at approximately 9:05 a.m., licensed assisted living director (LALD)-C confirmed she was unable to provide documented evidence of the above required training.<br><br>ULP-G<br>ULP-G began providing assisted living services on May 16, 2022.<br><br>On September 14, 2022, at approximately 7:00 a.m., the surveyor observed ULP-G administer insulin to R11 in his apartment.<br><br>ULP-G's employee record lacked documented evidence to indicate the employee completed training and/or practical skills evaluations as required in the following areas:<br>- recognizing physical, emotional, cognitive, and developmental needs of the resident.<br><br>ULP-H<br>ULP-H began providing assisted living services | 01380 | | |

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| 01380 | Continued From page 36<br>on June 28, 2022.<br><br>ULP-H's employee record lacked documented evidence to indicate the employee completed training and/or practical skills evaluations as required in the following areas:<br>- recognizing physical, emotional, cognitive, and developmental needs of the resident.<br><br>On September 14, 2022, at approximately 9:28 a.m., LALD-C confirmed she was unable to provide documented evidence of the above required training.<br><br>The licensee's Competency Training Evaluations policy, revised August 2021, indicated a registered nurse would provide training and competency evaluations for all ULP providing assisted living services, and would include recognizing physical, emotional, cognitive, and developmental needs of the resident.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 01380 | | |
| 01440 SS=F | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff | 01440 | | |

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| 01440 | Continued From page 37<br>performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.<br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for three of three unlicensed personnel ((ULP)-F, ULP-G and ULP-H).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>ULP-F, ULP-G and ULP-H's records lacked evidence to document an appropriate licensed professional or registered nurse provided direct | 01440 | | |

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| 01440 | Continued From page 38<br>supervision of staff performing delegated tasks as required.<br><br>ULP-F<br>ULP-F started employment on July 28, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021.<br><br>ULP-G<br>ULP-G began providing assisted living services on May 16, 2022.<br><br>ULP-H<br>ULP-H began providing assisted living services on June 28, 2022.<br><br>On September 14, 2022, at approximately 9:27 a.m., licensed assisted living director (LALD)-C verified an appropriate licensed professional or registered nurse had not completed a 30-day supervision on any unlicensed personnel as required.<br><br>The licensee's Supervision of Staff - Delegated Services policy dated August 2021 noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working and first performed the delegated tasks for the residents and thereafter as needed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01440 | | |
| 01470 SS=E | 144G.63 Subd. 2 Content of required orientation | 01470 | | |

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| 01470 | Continued From page 39<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research | 01470 | | |

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| 01470 | Continued From page 40<br>based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for three of five employees (unlicensed personnel (ULP)-F, ULP-G and ULP-H).<br><br>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 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).<br><br>The findings include:<br><br>ULP-F<br>ULP-F started employment on July 28, 2021, | 01470 | | |

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| 01470 | Continued From page 41<br>under the comprehensive home care license and began providing assisted living services on August 1, 2021.<br><br>ULP-F's employee record lacked documented evidence of the following:<br>- an overview of this chapter;<br>- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and<br>- a review of the types of assisted living services the employee would be providing and the facility's category of licensure.<br><br>On September 14, 2022, at approximately 9:05 a.m., licensed assisted living director (LALD)-C verified ULP-F's record lacked the above required orientation.<br><br>ULP-G<br>ULP-G began providing assisted living services on May 16, 2022.<br><br>ULP-G's employee record lacked documented evidence of the following:<br>- an overview of this chapter;<br>- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>- the principles of person-centered planning and service delivery and how they apply to direct | 01470 | | |

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| 01470 | Continued From page 42<br>support services provided by the staff person;<br>- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and<br>- a review of the types of assisted living services the employee would be providing and the facility's category of licensure.<br><br>On September 14, 2022, at approximately 9:27 a.m., LALD-C verified ULP-G's record lacked the above required orientation.<br><br>ULP-H<br>ULP-H began providing assisted living services on June 28, 2022.<br><br>ULP-H's employee record lacked documented evidence of the following:<br>- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>- consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>- a review of the types of assisted living services the employee would be providing and the facility's category of licensure. | 01470 | | |

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| 01470 | Continued From page 43<br><br>On September 14, 2022, at approximately 9:28 a.m., LALD-C verified ULP-H's record lacked the above required orientation.<br><br>The licensee's Orientation of Staff and Supervisors & Content policy dated August 2021 noted all staff must complete the orientation to assisted living facility requirements before providing services to the residents. It also noted the orientation must contain an overview of the assisted living statutes, an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person, principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person, handling of resident complaints, reporting of complaints and where to report complaints, including information on the Office of Health Facility Complaints and a review of the types of assisted living services the employee would be providing and the facility's category of licensure.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01470 | | |
| 01540 SS=E | 144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED<br><br>(3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not | 01540 | | |

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| 01540 | Continued From page 44<br>provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure staff completed the required amount of dementia care training (8 hours) in the required time frame (within 80 working hours) for four of five employees (licensed practical nurse (LPN)-B, unlicensed personnel (ULP)-F, ULP-G and ULP-H).<br><br>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 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).<br><br>The findings include:<br><br>The licensee had an Assisted Living with Dementia Care license, dated August 1, 2022.<br><br>LPN-B<br>LPN-B began providing assisted living services | 01540 | | |

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| 01540 | Continued From page 45<br>on July 1, 2022.<br><br>LPN-B's employee record contained evidence of 3.0 hours training on dementia care topics within 80 working hours of the start date. LPN-B reached 80 working hours on August 8, 2022.<br><br>ULP-F<br>ULP-F started employment on July 28, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021.<br><br>ULP-F's employee record contained evidence of 4.25 hours training on dementia care topics within 80 working hours of the start date. ULP-F reached 80 working hours on August 24, 2021. ULP-F's record contained evidence of additional hours of training on dementia care topics after working 80 hours, to complete the required 8.0 hours.<br><br>ULP-G<br>ULP-G began providing assisted living services on May 16, 2022.<br><br>ULP-G's employee record contained evidence of 3.0 hours training on dementia care topics within 80 working hours of the start date. ULP-G reached 80 working hours on June 13, 2022.<br><br>ULP-H<br>ULP-H began providing assisted living services on June 28, 2022.<br><br>ULP-H's employee record contained evidence of 3.0 hours training on dementia care topics within 80 working hours of the start date. ULP-H reached 80 working hours on July 6, 2022. | 01540 | | |

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| 01540 | Continued From page 46<br><br>On September 14, 2022, at approximately 9:20 a.m., licensed assisted living director (LALD)-C confirmed the employees had not completed the required amount of training on dementia care within the required time frame.<br><br>The licensee's Dementia Training policy dated August 2021 noted assisted living with dementia care licensed facilities would have direct-care employees complete eight hours of initial training within 80 hours of the employment start date.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01540 | | |
| 01610 SS=E | 144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. | 01610 | | |

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| 01610 | Continued From page 47<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial, comprehensive nursing assessment prior to signing the assisted living contract/providing services for two of four residents (R2, R3) as required.<br><br>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).<br><br>The findings include<br><br>During the entrance conference on September 12, 2022, at approximately 10:56 a.m., RN-A and licensed practical nurse (LPN)-B stated their understanding was nursing assessments should be completed by the RN, pre-admission to evaluate whether the licensee could meet their needs, upon admission, 14 days later, and then every 90 days or when there was a change in condition.<br><br>R2 and R3's records lacked evidence the RN completed a nursing assessment of the physical and cognitive needs of the resident prior to the date on which the resident executed a contract with the licensee or the date on which the resident moved in, whichever was earlier, as required. | 01610 | | |

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| 01610 | Continued From page 48<br><br>R2<br>R2 was admitted on February 1, 2022, and received services under the licensee's assisted living with dementia care license.<br><br>R2's diagnoses included major depressive disorder, unresolved grief, psychosis (severe mental disorder with impaired thoughts and emotions), and suicidal ideation.<br><br>On September 12, 2022, at approximately 12:11 p.m., the surveyor observed R2 sitting alone at the dining room table, waiting to be served.<br><br>R2's Planned Services, intended as the service plan, dated as of September 13, 2022, indicated R2 received meals, vital sign monitoring, safety checks, medication set-up, and medication administration.<br><br>R2's Resident Agreement was signed by R2 on February 10, 2022.<br><br>R2's Assessment As Of Date identified as the pre-admission assessment, was dated February 1, 2022. The pre-admission assessment included R2's code status, allergies, diagnoses, activities of daily living needs, medication administration needs, hearing, speech, vision, and vulnerabilities. The assessment did not include all of the elements on the uniform assessment tool, as required.<br><br>R2's Assessment As Of Date, identified as the admission assessment, indicated the assessment was completed in person by the RN on February 2, 2022, or the day after R2 moved into the facility. This assessment included all of the elements of the uniform assessment tool; | 01610 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MOTHER OF MERCY SENIOR LIVING | 230 CHURCH AVENUE ALBANY, MN 56307 |

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| 01610 | Continued From page 49 | 01610 | | |

however, was not completed prior to the date on which the prospective resident executed a contract with the facility or the date on which the prospective resident moved in, whichever was earlier, as required.

R3
R3 was admitted on June 24, 2022, and received services under the licensee's assisted living with dementia care license.

R3's diagnoses included diabetes, Parkinson's Disease, orthostatic hypotension (blood pressure decreases when standing), and diabetic polyneuropathy (peripheral nerve damage).

On September 13, 2022, at approximately 11:51 a.m., the surveyor observed R3 in the dining room, independently eating his lunch.

R3's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R3 received services which included assistance with dressing, oral care, and medication assistance.

R3's Assessment As Of Date identified as the pre-admission assessment, was dated June 23, 2022. The pre-admission assessment included R3's code status, allergies, diagnoses, activities of daily living needs, medication administration needs, hearing, speech, vision, and vulnerabilities. The assessment did not include all of the elements on the uniform assessment tool, as required.

R3's Assessment As Of Date, identified as the admission assessment, indicated the assessment was completed in person by the RN on June 27, 2022, or three days after R3 moved into the

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| 01610 | Continued From page 50<br>facility. This assessment included all of the elements of the uniform assessment tool; however, was not completed prior to the date on which the prospective resident executed a contract with the facility or the date on which the prospective resident moved in, whichever was earlier, as required.<br><br>On September 14, 2022, at approximately 12:47 p.m., RN-A verified the initial assessments which included all of the elements of the uniform assessment tool, should have been completed prior to the date on which the contract was executed, or on the date the residents moved into the facility, whichever was earlier, and verified R2 and R3's initial assessments were not completed timely.<br><br>The licensee's Assessments, Reviews & Monitoring policy, revised August 2021, indicated the RN would complete a nursing assessments of the resident's physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which the prospective resident executes a contract with the facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01610 | | |
| 01620 SS=E | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident | 01620 | | |

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| 01620 | Continued From page 51<br>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.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 14 days after the initiation of services as required for two of four residents (R2, R3).<br><br>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 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). | 01620 | | |

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| 01620 | Continued From page 52<br><br>The findings include:<br><br>During the entrance conference on September 12, 2022, at approximately 10:56 a.m., RN-A and licensed practical nurse (LPN)-B stated their understanding was nursing assessments should be completed by the RN, pre-admission to evaluate whether the licensee could meet their needs, upon admission, 14 days later, and then every 90 days or when there was a change in condition.<br><br>R2 and R3's records lacked evidence the RN completed a comprehensive reassessment no more than 14 days after the initiation of services, as required.<br><br>R2<br>R2 was admitted on February 1, 2022, and received services under the licensee's assisted living with dementia care license.<br><br>R2's diagnoses included major depressive disorder, unresolved grief, psychosis (severe mental disorder with impaired thoughts and emotions), and suicidal ideation.<br><br>On September 12, 2022, at approximately 12:11 p.m., the surveyor observed R2 sitting alone at the dining room table, waiting to be served.<br><br>R2's Planned Services, intended as the service plan, dated as of September 13, 2022, indicated R2 received meals, vital sign monitoring, safety checks, medication set-up, and medication administration.<br><br>R2's Resident Agreement was signed by R2 on February 10, 2022. | 01620 | | |

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| 01620 | Continued From page 53<br><br>R2's Assessment As Of Date identified as the "14 day f/u [follow up]," was dated February 16, 2022, or 15 days after the initiation of services, instead of no more than 14 days as required.<br><br>R3<br>R3 was admitted on June 24, 2022, and received services under the licensee's assisted living with dementia care license.<br><br>R3's diagnoses included diabetes, Parkinson's Disease, orthostatic hypotension (blood pressure decreases when standing), and diabetic polyneuropathy (peripheral nerve damage).<br><br>On September 13, 2022, at approximately 11:51 a.m., the surveyor observed R3 in the dining room, independently eating his lunch.<br><br>R3's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R3 received services which included assistance with dressing, oral care, and medication assistance.<br><br>R3's Assessment As Of Date, identified as the admission assessment, indicated the assessment was completed in person by the RN on June 27, 2022; however, R3's record lacked any further assessments, therefore, lacked an assessment no more than 14 days after the initiation of services, as required.<br><br>On September 14, 2022, at approximately 12:47 p.m., RN-A verified R2 and R3's 14-day assessments were not completed timely.<br><br>The licensee's Assessments, Reviews & Monitoring policy, revised August 2021, indicated | 01620 | | |

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| 01620 | Continued From page 54<br>resident reassessment and monitoring must be conducted no more than 14 calendar days after the initiation of services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01640 SS=F | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(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.<br>(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.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(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.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the | 01640 | | |

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| 01640 | Continued From page 55 | 01640 | | |

licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for four of four residents (R1, R2, R3 and R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1
R1's diagnoses included diabetes mellitus type 2.

R1's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R1 received services including blood glucose monitoring and medication administration. However, the service plan lacked a signature or other authentication by the facility and the resident/resident's representative, documenting agreement on the services to be provided.

R2
R2's diagnoses included major depressive disorder, unresolved grief, psychosis (severe mental disorder with impaired thoughts and emotions), and suicidal ideation.

R2's Planned Services, intended as the service plan, dated as of September 13, 2022, indicated R2 received services including meals, vital sign monitoring, safety checks, medication set-up, and

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| 01640 | Continued From page 56 | 01640 | | |

medication administration. However, the service plan lacked a signature or authentication by the facility and the resident/resident's representative, documenting agreement on the services to be provided.

R3
R3's diagnoses included diabetes, Parkinson's Disease, orthostatic hypotension (blood pressure decreases when standing), and diabetic polyneuropathy (peripheral nerve damage).

R3's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R3 received services which included assistance with dressing, oral care, and medication assistance. However, the service plan lacked a signature or authentication by the facility and the resident/resident's representative, documenting agreement on the services to be provided.

R4
R4's diagnoses included dementia.

R4's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R4 received services including assistance with oral cares and toileting, behavior monitoring, and medication administration. However, the service plan lacked a signature or other authentication by the facility and the resident/resident's representative, documenting agreement on the services to be provided.

On September 13, 2022, at approximately 9:05 a.m., licensed assisted living director (LALD)-C stated she had just printed out the planned services sheet to provide to the surveyors, which she identified as the service plan. LALD-C stated

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| 01640 | Continued From page 57<br>she provided the sheet to the resident/representative but did not have a signed copy for any of the residents, stating she was able to look it up in the electronic record if needed.<br><br>The licensee's Service Plan policy dated August 2021 noted the service plan and any revisions would include a signature or other authentication by the licensee and the resident or resident's representative, documenting agreement on the services to be provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |
| 01650 SS=F | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(iii) the names and contact information of persons the resident wishes to have notified in an | 01650 | | |

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| 01650 | Continued From page 58<br>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<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the service plan included the required content for four of four residents (R1, R2, R3 and R4).<br><br>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).<br><br>The findings include:<br><br>R1, R2, R3 and R4's service plans lacked the following required content:<br>- schedule and methods of monitoring reviews or assessments of the resident;<br>- schedule and methods of monitoring staff providing services; and<br>- a contingency plan that included the circumstances in which emergency medical services were not to be summoned consistent with chapters 145B and 145C, and the declarations made by the resident under those | 01650 | | |

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| 01650 | Continued From page 59<br>chapters.<br><br>R1<br>R1's diagnoses included diabetes mellitus type 2.<br><br>R1's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R1 received services including blood glucose monitoring and medication administration. However, the service plan lacked the above required content.<br><br>R2<br>R2's diagnoses included major depressive disorder, unresolved grief, psychosis (severe mental disorder with impaired thoughts and emotions), and suicidal ideation.<br><br>R2's Planned Services, intended as the service plan, dated as of September 13, 2022, indicated R2 received services including meals, vital sign monitoring, safety checks, medication set-up, and medication administration. However, the service plan lacked the above required content.<br><br>R3<br>R3's diagnoses included diabetes, Parkinson's Disease, orthostatic hypotension (blood pressure decreases when standing), and diabetic polyneuropathy (peripheral nerve damage).<br><br>R3's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R3 received services which included assistance with dressing, oral care, and medication assistance. However, the service plan lacked the above required content.<br><br>R4<br>R4's diagnoses included dementia. | 01650 | | |

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| 01650 | Continued From page 60<br><br>R4's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R4 received services including assistance with oral cares and toileting, behavior monitoring, and medication administration. However, the service plan lacked the above required content.<br><br>On September 14, 2022, at approximately 2:12 p.m., licensed assisted living director (LALD)-C verified the above required content was not included in the service plans, and confirmed the same template was utilized for all residents.<br><br>The licensee's Service Plan policy dated August 2021 noted the service plan would include:<br>- a schedule and method for the next planned assessment or monitoring;<br>- a schedule and method for the next plan monitoring of staff providing services; and<br>- a contingency plan that included how the facility would support documented resident health care directive decisions, if any including circumstances when emergency medical services would not be summoned.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01650 | | |
| 01690 SS=F | 144G.71 Subdivision 1 Medication management services<br><br>(a) This section applies only to assisted living facilities that provide medication management services.<br>(b) An assisted living facility that provides | 01690 | | |

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| 01690 | Continued From page 61<br>medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.<br>(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures that were developed under the supervision and direction of a registered nurse (RN).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 01690 | | |

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| | 30461 | A. BUILDING: _____ B. WING _____ | 09/15/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MOTHER OF MERCY SENIOR LIVING | 230 CHURCH AVENUE ALBANY, MN 56307 |

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| 01690 | Continued From page 62<br>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).<br><br>The findings include:<br><br>During the entrance conference on September 12, 2022, at approximately 10:05 a.m., licensed practical nurse (LPN)-B and licensed assisted living director (LALD)-C confirmed the licensee provided medication management services to the licensee's residents.<br><br>The licensee lacked the following required policies:<br>- verifying that prescription drugs were administered as prescribed; and<br>- communicating with the pharmacist.<br><br>On September 14, 2022, at approximately 2:40 p.m., regional clinical director (RCD)-E confirmed the above required policies could not be located.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Seven (7) days. | 01690 | | |
| 01730 SS=D | 144G.71 Subd. 5 Individualized medication management plan<br><br>(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 | 01730 | | |

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| 01730 | Continued From page 63<br>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:<br>(1) a statement describing the medication management services that will be provided;<br>(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;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(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.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record | 01730 | | |

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| 01730 | Continued From page 64<br>review, the licensee failed to develop an individualized medication management record with the required content for one of four residents (R3) reviewed.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on September 12, 2022, at approximately 10:56 a.m., licensed practical nurse (LPN)-B and registered nurse (RN)-A indicated the licensee provided medication management services for the licensee's residents.<br><br>R3<br>R3's record lacked a medication management plan to include the following required content:<br>- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions.<br><br>R3 began receiving services on June 24, 2022, with diagnoses that included diabetes, Parkinson's Disease, orthostatic hypotension (blood pressure decreases when standing), and diabetic polyneuropathy (peripheral nerve damage).<br><br>On September 13, 2022, at approximately 11:51 | 01730 | | |

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| 01730 | Continued From page 65<br>a.m., the surveyor observed R3 in the dining room, independently eating his lunch.<br><br>R3's prescriber orders dated August 17, 2022, included an antidepressant, two supplements, three oral medications to treat diabetes, one medication to treat low blood pressure, one sleep aide, and one anti-Parkinson's medication.<br><br>R3's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R3 received services which included assistance with dressing, oral care, and medication assistance.<br><br>R3's Assessment As Of Date, dated June 27, 2022, indicated R3 required staff to administer medications, ordering, and medication set-up, and noted the licensed nurse was responsible for monitoring medication supplies and ensuring medication refills were ordered on a timely basis; however, lacked the above required content.<br><br>On September 14, 2022, at approximately 10:08 a.m., RN-A and LPN-B verified R3's record lacked a medication management plan with the above required content.<br><br>The licensee's Medication Storage policy, revised August 2021, indicated medication would be stored consistent with each residents' medication management plan and service plan.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |

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| 01790 | Continued From page 66 | 01790 | | |
| 01790 SS=F | 144G.71 Subd. 10 Medication management for residents who will<br><br>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;<br>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and<br>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.<br>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:<br>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and<br>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:<br>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;<br>(ii) how the container or containers must be labeled;<br>(iii) written information about the medications to be provided;<br>(iv) how the unlicensed staff must document in | 01790 | | |

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| 01790 | Continued From page 67<br>the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;<br>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;<br>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and<br>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to | 01790 | | |

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| 01790 | Continued From page 68<br>affect a large portion or all of the residents).<br><br>The findings include:<br><br>During the entrance conference on September 12, 2022, at approximately 10:05 a.m., licensed practical nurse (LPN)-B and licensed assisted living director (LALD)-C confirmed the licensee provided medication management services to the licensee's residents.<br><br>The licensee's Medication Management - Planned Unplanned Time Away policy dated August 2021 noted for unplanned resident time away when a pharmacist or licensed nurse is not available, the RN could delegate the task to the unlicensed personnel (ULP) if the RN had developed written procedures to address:<br>- the type of container or containers to be used for the medications appropriate to the provider's medication system;<br>- how the container or containers must be labeled;<br>- the written information about the medications to be given to the resident or resident's representative;<br>- how the ULP must document in the resident's record that medications had been given to the resident or the resident's representative, including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information;<br>- how the RN should be notified that medications had been given to the resident or resident's representative and whether the RN needed to be contacted before the medications were given to the resident or resident's representative; | 01790 | | |

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| 01790 | Continued From page 69<br>- a review by the RN of the completion of this task to verify the task was completed accurately by the ULP; and<br>- how the ULP must document in the resident's record any unused medications that had been returned to the provider, including the name of each medication and the doses of each returned medication.<br><br>The licensee's Step by Step Instructions for Sending Meds (Medications) LOA (Leave of Absence) form lacked instruction to include:<br>- how the RN should be notified that medications had been given to the resident or resident's representative and whether the RN needed to be contacted before the medications were given to the resident or resident's representative;<br>- a review by the RN of the completion of this task to verify the task was completed accurately by the ULP; and<br>- how the ULP must document in the resident's record any unused medications that had been returned to the provider, including the name of each medication and the doses of each returned medication.<br><br>On September 14, 2022, at approximately 2:40 p.m., regional clinical director (RCD)-E stated new procedures were available to include the required content, but had not been implemented yet.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01790 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications | 01880 | | |

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| 01880 | Continued From page 70<br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access for two of two residents (R12, R13) observed during medication administration in Fairway Ridge.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on September 12, 2022, at approximately 10:56 a.m., licensed practical nurse (LPN)-B and registered nurse (RN)-A indicated the licensee provided medication management services for the licensee's 46 residents, including medication set up for later administration by the trained unlicensed personnel (ULP). LPN-B and RN-A indicated medications were stored in a medication cart in Memory Lane and in Grace Court, and extra medications for Memory Lane | 01880 | | |

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| 01880 | Continued From page 71 | 01880 | | |

and Fairway Ridge were kept in locked cupboards with only staff having access to keys, in Memory Lane. LPN-B and RN-A did not mention where medications were stored in the Fairway Ridge building.

R12
R12's diagnoses included osteopenia (loss of bone mineral density), cancer, atrial fibrillation (irregular, rapid heartbeat), anxiety, hypertension (high blood pressure), hyperlipidemia (too many lipids).

R12's Assessment As Of Date, dated July 15, 2022, indicated R12 required medication management and medication administration, and noted medications were stored in a locked box in the resident's apartment with spare medication stored in a locked medication cupboard in Memory Lane.

R12's physician orders, dated July 10, 2022, included one antidepressant, four supplements, one medication to treat chest pain, one medication to decrease edema, two heart medications, and one laxative.

On September 13, 2022, at approximately 8:28 a.m., the surveyor observed while ULP-G entered R12's room, and prepared to give R12's medications. ULP-G referred to her portable device for R12's list of medications, and went to the top of R12's refrigerator to retrieve a large yellow tackle box with a small padlock, marked "AM" with a piece of masking tape. The surveyor observed another large black tackle box on top of the refrigerator with a piece of masking tape with "PM" written on it. ULP-G used a key to open the yellow tackle box and proceeded to set up R12's medication from punch packs, into a plastic

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| 01880 | Continued From page 72 | 01880 | | |

medication cup. ULP-G verified the medications on the electronic medical record on the device, dumped the medications into a medication cup, and handed the medication cup to R12. R12 poured the contents of the medication cup into her hand, handed one of the pills to ULP-G, and asked her to cut it in half for easier swallowing. ULP-G cut the tablet in half and R12 swallowed one medication at a time, followed by liquid from a cup. ULP-G exited R12's room and performed hand hygiene with hand sanitizer.

R13
R13's diagnoses included encephalopathy, osteoarthritis, weakness, disorientation, anxiety, chronic kidney disease, pacemaker, insomnia, prediabetes, and glaucoma.

R13's Assessment As Of Date, dated August 17, 2022, indicated R13 required staff to administer all medications as ordered by her physician and facility policy, and noted R13's medications were stored in a locked box in R13's room.

R13's prescriber's orders, dated February 21, 2022, included one medication to treat gout, one heart health medication, one medication to treat high blood pressure, one medication to prevent blood clots, one medication to treat allergies, an antidepressant, two supplements, and a medication to decrease edema.

On September 13, 2022, at approximately 8:45 a.m., the surveyor observed ULP-G enter R13's room after knocking and wake R13 to administer her medications. ULP-G obtained a large black tackle box from an unlocked cabinet in the kitchen. ULP-G used a device to check R13's pulse, unlocked the padlock on the tackle box, and proceeded to punch medications from punch

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| 01880 | Continued From page 73<br>packs in the tackle box, into a plastic medication cup. ULP-G brought the medication cup to R13, which she brought to her mouth and drank liquid from a cup to swallow the medications. ULP-G exited R13's room.<br><br>On September 13, 2022, at approximately 9:07 a.m., ULP-G stated all residents in Fairway Ridge, except one, had medications stored in a locked tackle box in their rooms, stored in various locations, mostly in the kitchen. ULP-G stated she thought storing the medications in a tackle box in the residents' rooms without securing it in a locked cupboard, was "weird," because if anyone wanted them, they could carry the tackle box out of the room and stomp on it to access the medications.<br><br>On September 14, 2022, at approximately 9:50 a.m., RN-A and LPN-B stated they were both new to the facility, and stated they had concerns about the security of the medications being stored in tackle boxes rather than a substantially constructed compartment that only authorized personnel could access.<br><br>The licensee's Medication Storage policy, revised August 2021, directed medications managed by the licensee would be kept securely locked and stored per manufacturer's directions, and only authorized staff would have access to stored medications. Further, the policy indicated medications managed inside a resident's private living space must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access, which may be a locked drawer, cabinet, etc.<br><br>No further information was provided. | 01880 | | |

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| 01880 | Continued From page 74<br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01890 SS=E | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to date time-sensitive medications with a date when opened for two of two residents (R1 and R11) with insulin.<br><br>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 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).<br><br>The findings include:<br><br>During the entrance conference on September 12, 2022, at approximately 10:05 a.m., licensed practical nurse (LPN)-B and licensed assisted living director (LALD)-C confirmed the licensee provided medication management services to the licensee's residents. | 01890 | | |

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| MOTHER OF MERCY SENIOR LIVING | 230 CHURCH AVENUE ALBANY, MN 56307 |

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| 01890 | Continued From page 75<br><br>On September 13, 2022, at approximately 2:28 p.m., the surveyor observed the medication cart on the memory care unit with LPN-B. R1's Levemir FlexTouch insulin pen lacked a date to indicate when staff opened it, or when it would expire. LPN-B confirmed the findings and verified insulin pens should be dated when opened and when they would expire.<br><br>The Levemir FlexTouch insulin manufacturer's directions for use dated September 2022 noted for storage after use "Dispose after 42 days, even if there is insulin left in the pen or vial".<br><br>On September 14, 2022, at approximately 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-G administer insulin to R11 in his apartment. R11's Lantus SoloStar insulin pen lacked a date to indicate when staff opened it, or when it would expire. Upon exiting R11's room, ULP-G stated she had not been trained to date the insulin pens when opening them.<br><br>The Lantus SoloStar insulin pen manufacturer's directions for use dated March 2020 noted for storage of opened pens "After 28 days, throw your Lantus pen away - even if it has insulin in it".<br><br>On September 14, 2022, at approximately 12:50 p.m., LPN-B and registered nurse (RN)-A confirmed all insulin pens should be dated when opened and had provided education to staff after questioning by the surveyor, to ensure it was being done going forward.<br><br>The licensee's Medication Beyond Use Dating - Assisted Living policy dated September 2022, noted "Multi-dose medications with a manufacturer assigned beyond-use date will be dated with an open and/or discard date upon first | 01890 | | |

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| 01890 | Continued From page 76<br>use".<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 02040 SS=F | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements:<br>(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<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:<br>Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. This had the potential to directly affect all residents and staff.<br><br>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 | 02040 | | |

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| 02040 | Continued From page 77<br>of the residents). The findings include:<br><br>On September 13, 2022, at approximately 12:45 p.m., documents were provided by the regional clinical director (RCD)-E for review. Documents were reviewed by survey staff on September 13, 2022, between 12:45 p.m. and 1:45 p.m. The Hazard Vulnerability Assessment Tool did not include hazards or safety risks identified on and around the property and mitigation to protect residents from harm.<br><br>On September 13, 2022, at approximately 1:50 p.m., the licensed assisted living director (LALD)-C confirmed during the exit interview that the assessment tool did not include safety risks or hazards identified on and around the property. They also confirmed that mitigation of property hazards to protect residents from harm was not included in the assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02040 | | |
| 02110 SS=F | 144G.82 Subd. 3 Policies<br><br>(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:<br>(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;<br>(2) evaluation of behavioral symptoms and | 02110 | | |

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| 02110 | Continued From page 78<br>design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;<br>(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;<br>(4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;<br>(5) staff training specific to dementia care;<br>(6) description of life enrichment programs and how activities are implemented;<br>(7) description of family support programs and efforts to keep the family engaged;<br>(8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;<br>(9) transportation coordination and assistance to and from outside medical appointments; and<br>(10) safekeeping of residents' possessions.<br>(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in. This had the potential to affect all residents.<br><br>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 | 02110 | | |

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| 02110 | Continued From page 79<br>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).<br><br>The findings include:<br><br>The licensee lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative.<br><br>The licensee had an Assisted Living with Dementia Care license, dated August 1, 2022, and was licensed for a bed capacity of 79 residents.<br><br>On September 14, 2022, at approximately 2:12 p.m., licensed assisted living director (LALD)-C confirmed the inclusive list of dementia care policies had not been provided to each resident and/or representative.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 02110 | | |
| 02260 SS=C | 144G.90 Subd. 3 Notice of dementia training<br><br>An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon | 02260 | | |

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| 02260 | Continued From page 80<br>request.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, an accurate description of the dementia care training program with the required content.<br><br>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).<br><br>The findings include:<br><br>The licensee had an Assisted Living with Dementia Care license, dated August 1, 2022.<br><br>During the entrance conference on September 12, 2022, at approximately 10:05 a.m., licensed assisted living director (LALD)-C verified the licensee had a locked dementia unit.<br><br>The licensee's undated Notice of Dementia Training noted the topics covered would include an explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, and communication skills. However, it lacked inclusion of person-centered planning and service delivery. In addition, the form noted direct-care staff must complete at least eight hours of dementia training within 160 working hours, not | 02260 | | |

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| 02260 | Continued From page 81<br>within 80 working hours as required with the license type.<br><br>On September 13, 2022, at approximately 12:50 p.m., LALD-C confirmed the form lacked the complete topics covered and the correct timeframe to complete the training.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 02260 | | |
| 02310 SS=I | 144G.91 Subd. 4 Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for four of four residents (R10, R8, R9, R7) with an assistive device (consumer bed rail) and two of two residents (R6, R3) with hospital-style bed rails.<br><br>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 widespread scope (when problems are pervasive or represent a systemic failure that | 02310 | On September 15, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a level 3, scope of widespread violation. | |

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| 02310 | Continued From page 82 | 02310 | | |

has affected or has potential to affect a large portion or all of the residents).

This practice resulted in an immediate order for correction on September 14, 2022.

The findings include:

ASSISTIVE DEVICE

R10
On September 13, 2022, at approximately 1:10 p.m., the surveyor observed registered nurse (RN)-A measure R10's assistive device on the right side of his bed. The device was a single, metal, wrapped in white plastic, rectangular-shaped device, and had two straight metal bars, approximately 35 inches long, that slid between the mattress and the bed frame. The assistive device had an opening that measured 19 inches in width, and 14.5 inches from the top of the device to the bottom of the mattress. R10 stated he had the device "for years," and used the assistive device to get in and out of bed. R10 stated the assistive device was purchased at a store in St. Cloud, and stated he had no idea where the manufacturer's instructions were or the make/model of the device.

R10's diagnoses included coronary artery disease, osteoarthritis, shortness of breath, and lumbar disc disease.

R10's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R10 received services which included vital monitoring and a daily safety check.

R10's Assessment As Of Date, dated July 25, 2022, indicated R10 was independent with

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| 02310 | Continued From page 83 | 02310 | | |

mobility and could transfer or ambulate without assistance. The assessment also indicated R10 had an electric bed with a partial side rail, and noted, "The bed safety zone assessment is not applicable, either resident has no bed rails in use or has portable bed rails that are installed on a consumer bed."

R10's Restraints: Side Rail Utilization Assessment, dated February 10, 2017, indicated R10 did not request side rails; however, "Wife will but not him." The assessment also indicated the resident/legal surrogate had been informed about side rail risks and signed statement of understanding. The assessment indicated R10 could get in and out of bed safely without any human assistance or assistive device. The assessment indicated, "No side rail indicated because (check one of the following options);" however, nothing was checked. The assessment further included, in the comment section, "Tenant is not using side rail, but wife will when she comes to AL [assisted living] from NH [nursing home]." R10 signed the document on February 10, 2017.

R10's record lacked a comprehensive assessment of the use of an assistive device, including installation and use of the device according to manufacturer's guidelines, lacked evidence of physical inspection of the bed rail and mattress for areas of entrapment, stability, and correct installation of the device, and lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bed rail recall information. R10's record also lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative. The record lacked information related to interventions implemented by the

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| 02310 | Continued From page 84<br>licensee to mitigate the resident's risk for safety pertaining to the use of the device.<br><br>R8<br>On September 13, 2022, at approximately 1:39 p.m., the surveyor observed RN-A measure R8's assistive device on the right side of her bed. The device was a single, metal, partially wrapped in black foam and duct tape that was hanging off, bell-shaped device, and had a large u-shaped metal bar, that slid under the mattress. A long black strap was attached to the u-shaped bar; however, was hanging out from under the mattress on the left side of the bed, not attached to anything. The assistive device had an opening that measured 12 inches in width at the mattress level, and 20 inches from the top of the device to the bottom of the mattress. R8 was not present in the room during the observation.<br><br>R8's diagnoses included coronary artery disease, high blood pressure, mixed incontinence, memory impairment, sleepiness, hip arthritis, and history of hip replacement.<br><br>R8's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R8 received services which included assistance with toileting and bathing and dressing.<br><br>R8's Assessment As Of Date, dated August 25, 2022, indicated R8 used a wheeled walker and a wheelchair at times. R8 used a standard bed with a side rail or bed positioning device, identified as a partial side rail to aid in transfers and to and from bed. The assessment indicated R8's family member was given a safety pamphlet. In addition, the assessment questioned whether the device met the Food and Drug Administration (FDA) | 02310 | | |

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| 02310 | Continued From page 85<br>requirements, and noted "Partial side rail," and "The bed safety zone assessment is not applicable, either resident has no bed rails in use or has portable bed rails that are installed on a consumer bed."<br><br>R8's record lacked the document Restraints: Side Rail Utilization Assessment.<br><br>R8's record lacked a comprehensive assessment of the use of an assistive device, including installation and use of the device according to manufacturer's guidelines, lacked evidence of physical inspection of the bed rail and mattress for areas of entrapment, stability, and correct installation of the device, and lacked evidence the licensee referred to the CSPC for bed rail recall information. R8's record also lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative. The record lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device.<br><br>R9<br>On September 13, 2022, at approximately 1:43 p.m., the surveyor observed RN-A measure R9's assistive device on the right side of her bed. The device was a single, metal, rectangular-shaped device, and had a large u-shaped metal bar, that slid under the box spring, coming to rest under the bed, on the floor. RN-A readjusted the device, and slid the u-shaped bar between the mattress and the box spring. The assistive device had an opening that measured 19 inches in width and 20 inches in length from the top of the device to the bottom of the mattress, and 15 inches from the top of the device to the top of the mattress. R9 stated she used the device to get in and out of | 02310 | | |

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| 02310 | Continued From page 86<br>bed and stated her children brought in the device with no manufacturer's information that she was aware of.<br><br>R9's diagnoses included atrial fibrillation, macular degeneration, glaucoma, osteoporosis, muscle weakness, and obstructive sleep apnea.<br><br>R9's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R9 received services which included behavior monitoring, medication administration, and incontinence care.<br><br>R9's Assessment As Of Date, dated August 15, 2022, indicated R9 was independent with bed mobility or with an assistive device, was able to independently transfer but had limited mobility due to age related osteoporosis, muscle weakness, and polyneuropathy (damaged peripheral nerves). R9 used a walker or wheelchair for off unit mobility and used a standard bed and mattress with a partial side rail to aid in transfers to and from bed, and indicated education had been provided on the risks of the side rails and understanding verbalized.<br><br>R9's record lacked the document Restraints: Side Rail Utilization Assessment.<br><br>R9's record lacked a comprehensive assessment of the use of an assistive device, including installation and use of the device according to manufacturer's guidelines, lacked evidence of physical inspection of the bed rail and mattress for areas of entrapment, stability, and correct installation of the device, and lacked evidence the licensee referred to the CSPC for bed rail recall information. R9's record also lacked evidence of an individualized risk and benefit discussion with | 02310 | | |

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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 |
|---|---|---|---|---|
| 02310 | Continued From page 87 | 02310 | | |

the resident or the resident's representative. The record lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device.

R7
On September 13, 2022, at approximately 1:49 p.m., the surveyor observed RN-A measure R7's assistive device on the right side of her bed. The device was a single, metal, rectangular-shaped device, with poles on each side that extended to the floor with a rubber stopper, measuring 33 inches in length. The device had a large u-shaped metal bar, that slid under the mattress approximately 2/3 of the way across the twin mattress. The assistive device had an opening that measured 16 inches in width and 8 inches in length from the top of the device to the top of the mattress. R7 was not present during the observation.

R7's diagnoses included late onset Alzheimer's Disease, coronary artery disease, osteoarthritis of both knees, high blood pressure, osteoporosis, and lower extremity edema.

R7's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R7 received services which included assistance with toileting, oxygen maintenance, and medication administration.

R7's Assessment As Of Date, dated August 29, 2022, indicated R7 was independent with bed mobility or with an assistive device, had bilateral knee and back brace, with standby assist for transferring, used a walker and wheelchair with long distances. The assessment indicated R7 had a partial side rail, identified as a portable bed

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|---|---|---|---|
| | 30461 | A. BUILDING: _____ B. WING _____ | 09/15/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOTHER OF MERCY SENIOR LIVING | 230 CHURCH AVENUE ALBANY, MN 56307 |

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| 02310 | Continued From page 88<br>rail.<br><br>R7's record lacked the document Restraints: Side Rail Utilization Assessment.<br><br>R7's record lacked a comprehensive assessment of the use of an assistive device, including installation and use of the device according to manufacturer's guidelines, lacked evidence of physical inspection of the bed rail and mattress for areas of entrapment, stability, and correct installation of the device, and lacked evidence the licensee referred to the CSPC for bed rail recall information. R7's record also lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative. The record lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device.<br><br>HOSPITAL BEDS<br><br>R6<br>On September 13, 2022, at approximately 1:25 p.m., the surveyor observed RN-A measure R6's bilateral bed rails affixed to the hospital bed. Both bed rails were in the raised position, and were very loose, being able to freely move each rail side to side and front to back. The nine openings between the bars for zone 1 varied in size, with the largest opening measuring 4 inches. The measurements between the mattress and the bedrail for zone 3, measured 1 inch. R6 stated she didn't think she used the bed rails much.<br><br>R6's diagnoses included weakness, pain, and Rhabdomyolysis (muscle tissue breakdown).<br><br>R6's Planned Services, identified as the | 02310 | | |

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| 02310 | Continued From page 89<br><br>licensee's service plan, as of September 13, 2022, indicated R6 received services which included medication assistance, assistance with bathing, behavior monitoring, and grooming reminders.<br><br>R6's Assessment As Of Date, dated July 18, 2022, indicated R6 was independent with bed mobility or with an assistive device, used a side rail or bed positioning device on an electric hospital bed to define the edge of the bed for moving within the bed, getting in and out of bed, to provide a feeling of comfort and security, and to aid in turning and repositioning in bed. The assessment indicated family or resident had been provided education about the device to include "A Guide to Bed Safety." The assessment identified the bed rail as a partial side rail, bilateral half that was "compliant" with FDA requirements.<br><br>R6's record lacked the document Restraints: Side Rail Utilization Assessment.<br><br>R6's record lacked a comprehensive assessment of the hospital bed rails to include the measurements of zones 1, 2, and 3 of the FDA guidelines and lacked evidence of physical inspection of the bed rail and mattress for areas of entrapment and stability of the device including installation and use of the device according to manufacturer's guidelines. R6's record also lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative. The record lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device.<br><br>R3<br>On September 13, 2022, at approximately 1:55 | 02310 | | |

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| 02310 | Continued From page 90<br>p.m., the surveyor observed RN-A measure R3's bilateral bed rails affixed to the hospital bed. R3's head of bed was slightly elevated, both bed rails were in the raised position, and were very loose, being able to freely move each rail side to side and front to back. The nine openings between the bars for zone 1 varied in size, with the largest opening measuring 4.5 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. R3 was not in the room during the observation.<br><br>R3's diagnoses included diabetes, Parkinson's Disease, orthostatic hypotension (blood pressure decreases when standing), and diabetic polyneuropathy (peripheral nerve damage).<br><br>R3's Planned Services, identified as the licensee's service plan, as of September 13, 2022, indicated R3 received services which included assistance with dressing, oral care, and medication assistance.<br><br>R3's Assessment As Of Date, dated June 27, 2022, indicated R3 was independent with ambulation using a wheeled walker or wheelchair for long distances, was independent with bed mobility or with an assistive device, and used a partial bilateral side rail or devices on an electric hospital bed. The assessment questioned whether the device met FDA requirements, and noted "Partial side rail." The assessment indicated the indications for use included, "Benefits resident in all bed mobility." The assessment indicated education had been provided to the resident and/or responsible party of the risks of the side rails and verbalized understanding.<br><br>R3's Restraints: Side Rail Utilization Assessment, | 02310 | | |

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| 02310 | Continued From page 91<br><br>dated June 24, 2022, indicated the resident had requested the side rails, and preferred two half rails. The assessment noted the resident had a history of falls but not from the bed/weakness, and indicated R3 could not get in and out of bed safely without any human assistance or assistive device. Further, the assessment noted both side rails were the least restrictive device based on resident physical or emotional needs. The assessment was signed by R3 on June 24, 2022.<br><br>R3's record lacked a comprehensive assessment of the hospital bed rails to include the measurements of zones 1, 2, and 3 of the FDA guidelines and lacked evidence of physical inspection of the bed rail and mattress for areas of entrapment and stability of the device including installation and use of the device according to manufacturer's guidelines. R3's record also lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative. The record lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device.<br><br>On September 13, 2022, at approximately 2:05 p.m., RN-A stated she had just started at this facility and wasn't aware of the requirements when residents utilized bed rails.<br><br>The licensee's Side Rails policy, dated August 2021, noted when a resident utilized a side rail on a bed, the licensee would assess the use, educate the resident or representative about the risk and benefits of the side rails, and verify the side rail in use was a safe design and utilized consistent with the manufacturer's directions. In addition, it noted the facility would determine as safe by meeting all the requirements below: | 02310 | | |

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| 02310 | Continued From page 92<br>- The side rails was used consistent with manufacturer's directions;<br>- The side rails were installed securely and maintained in good operating condition, and be aware of wobbly rails; and<br>- The side rail design was consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment, to mean side rail zones 1, 2 and 3 must not exceed 4.75".<br><br>The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:<br>- Purpose and intention of the bed rail;<br>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;<br>- The resident's bed rail use/need assessment;<br>- Risk vs. benefits discussion (individualized to each resident's risks);<br>- The resident's preferences;<br>- Installation and use according to manufacturer's guidelines;<br>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and | 02310 | | |

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| 02310 | Continued From page 93<br>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".<br>Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations.<br><br>The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE | 02310 | | |
| 03090 SS=C | 144.6502, Subd. 8 Notice to Visitors<br><br>Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."<br><br>(b) The facility is responsible for installing and maintaining the signage required in this | 03090 | | |

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| 03090 | Continued From page 94<br>subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors of the licensee.<br><br>This practice resulted in a level one violation (a violation that has not 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).<br><br>The findings include:<br><br>On September 12, 2022, at approximately 11:30 a.m., the surveyors toured the facility with licensed assisted living director (LALD)-C and regional clinical director (RCD)-E. The facility had three main entrances that could be utilized to enter the facility. However, the required posting related to electronic monitoring was not noted at any of the entrances.<br><br>On September 12, 2022, at approximately 3:25 p.m., LALD-C confirmed none of the entrances to the facility had the required electronic posting notice.<br><br>The licensee's Electronic Monitoring policy dated August 2021 noted signs were installed at each facility entrance accessible to visitors to state | 03090 | | |

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| 03090 | Continued From page 95<br>"Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities".<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 03090 | | |

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

Type: Full
Date: *09/12/22*
Time: 13:44:57
Report: 8042221187

# Food and Beverage Establishment Inspection Report



**Location:**
Mother Of Mercy Senior Living
230 Church Avenue
Albany, MN56307
Stearns County, 73

**Establishment Info:**
ID #: 0037898
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 3208452195
ID #:

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

The following orders were issued during this inspection.

**4-300 Equipment Numbers and Capacities**
***4-302.12B*** ***** 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.

PROVIDE THIN TIP THERMOMETERS TO ACCURATELY CHECK THE TEMPERATURE OF THIN FOODS.

*Comply By: 09/19/22*

**4-300 Equipment Numbers and Capacities**
***4-302.13B*** ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE A WAY TO MONITOR THE TEMPERATURE OF 2 DISHWASHERS AT PLATE LEVEL.

*Comply By: 09/26/22*

**4-500 Equipment Maintenance and Operation**
***4-501.116*** ***** Priority 2 *****

MN Rule 4626.0815 Use the sanitizer test kit or other device to accurately measure the concentration of the sanitizing solution.

PROVIDE CHLORINE TEST STRIPS TO MONITOR SANITIZER CONCENTRATION AT 2 DISHWASHERS.

*Comply By: 09/26/22*

**4-900 Protecting Clean Items**

***4-901.11***

MN Rule 4626.0935 Allow equipment and utensils to air-dry after cleaning and sanitizing; only use cloths that are clean and dry for polishing utensils that have been air dried.

DISCONTINUE DRYING CLEAN ITEMS ON A TOWEL IN MEMORY LANE.

*Comply By: 09/12/22*

**6-300 Physical Facility Numbers and Capacities**

***6-301.14A***

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

PROVIDE HAND WASH SIGNS AT ALL HAND SINKS (MEMORY LANE, GRACE COURT).

*Comply By: 09/16/22*

**6-500 Physical Facility Maintenance/Operation and Pest Control**

***6-501.11***

MN Rule 4626.1515 Maintain the physical facilities in good repair.

REPAIR HOLES IN THE WALL UNDER THE DISH MACHINE IN FAIRWAY RIDGE.

*Comply By: 09/26/22*

**Surface and Equipment Sanitizers**

Chlorine: = 100 at Degrees Fahrenheit
Location: DISH MACHINE-FAIRWAY RIDGE
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE-MAIN KITCHEN
Violation Issued: No

Hot Water: = at 170 Degrees Fahrenheit
Location: DISH MACHINE-MEMORY LANE
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cooking
Temperature: 196 Degrees Fahrenheit - Location: HAMBURGER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 180 Degrees Fahrenheit - Location: POTATOES
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: CUT CANTALOUPE
Violation Issued: No

Type: Full
Date: *09/12/22*
Time: 13:44:57
Report: 8042221187
Mother Of Mercy Senior Living

# Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: YOGURT
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8042221187 of 09/12/22.

Certified Food Protection Manager: DAVID PYKA

Certification Number: 70654 Expires: 02/01/24

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
Establishment Representative

Signed: EH
Erin Hodgins
Public Health Sanitarian
651-201-4500
health.foodlodging@state.mn.us