Electronically Delivered

January 10, 2023

Licensee
American Eagle Owatonna
334 Cedardale Drive Southeast
Owatonna, MN 55060

RE: Project Number(s) SL30559015

Dear Licensee:

On December 28, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on August 12, 2022. This follow-up evaluation determined your facility had corrected all of the state licensing orders issued pursuant to the August 12, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on August 12, 2022, found not corrected at the time of the December 28, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9

The details of the violations noted at the time of this follow-up evaluation completed on December 28, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

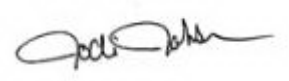
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

Please note, 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.

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30559	A. BUILDING: _____ B. WING _____	R 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	334 CEDARDALE DRIVE SE OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL30559015-2 On December 28, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 16, 2022. At the time of the survey, there were 17 residents: 16 of whom were receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 660} SS=E	144G.42 Subd. 9 Tuberculosis prevention and control	{0 660}		

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{0 660}	Continued From page 1 (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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: 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), which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for two of four employees (unlicensed personnel (ULP)-J, ULP-M) per CDC guidelines. In addition, the licensee failed to document a TST result in millimeters (mm) of induration for two of four employees (ULP-M, ULP-N). 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	{0 660}		

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{0 660}	Continued From page 2 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's Facility TB Risk Assessment dated September 20, 2022, indicated the licensee was a low risk level. ULP-J ULP-J began providing direct care services for the licensee on September 9, 2022. ULP-J's employee record contained a Baseline TB Screening Tool for Health Care Workers (HCW) dated November 17, 2022, and a first step TST (no time was documented). The first step TST was read on November 22, 2022, (five days after test administration). In addition, ULP-J had a second step TST administered November 28, 2022, (no time documented) and read December 2, 2022, (four days after test administration). ULP-M ULP-M began providing direct care services for the licensee on March 28, 2022. ULP-M's employee record contained a Baseline TB Screening Tool for Health Care Personnel (HCP) dated April 18, 2022, and a first step TST administered April 17, 2022. The first step TST was read April 20, 2022, and documented as "negative"; however, it was not read in mm of induration. A second step TST was not administered until July 20, 2022, (three months later) and read July 23, 2022. ULP-N	{0 660}		

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{0 660}	Continued From page 3 ULP-N began providing direct care services for the licensee on June 29, 2022. ULP-N's employee record contained a Baseline TB screening Tool for HCW dated June 29, 2022, and a first step TST. The first step TST was read on July 1, 2022, and documented as "negative"; however, it was not read in mm of induration. A second step TST was administered July 13, 2022, and read July 15, 2022. The result was documented as "negative" not in mm of induration. On December 28, 2022, at 3:30 p.m. registered nurse (RN)-L stated she was aware a TST must be read within 48-72 hours. RN-L stated she remembered reading the TST, but did not know why both times it was documented late. RN-L further stated all TST results are to be documented in mm of induration. Assisted living director residency permit (ALDRP)-B stated the previous nurse did not utilize a correct schedule to administer the two step TST's and verified the above findings. The licensee's 8.16 Tuberculosis Screening policy dated September 27, 2022, indicated the licensee would establish and maintain a comprehensive TB infection control program according to the most current TB infection control guidelines issued by the CDC. The policy directed staff whose essential job functions require work within the same air space of home care clients, instead of assisted living residents, would be screened and tested for TB prior to the staff being exposed to clients. The policy also indicated new staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCW (health care workers), and would have a blood test or a two-step Mantoux (tuberculin skin test)	{0 660}		

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{0 660}	Continued From page 4 conducted with results documented, and no staff would be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux were read and documented in the employee medical file. MDH guideline, 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 starts working with patients. Baseline TB screening should be documented in the employee's record. MDH Two-Step TST algorithm dated October 26, 2022, indicated a second TST should be administered 1-3 weeks after the first TST. MDH TST Basics dated November 9, 2022, indicated a TST reaction should be read between 48 and 72 hours after administration. If the test is not read within 72 hours, another TST should be placed unless the amount of induration is greater than or equal to 10 mm within seven days after placement. The reaction should be measured in mm of induration (palpable, raised, hardened area or swelling). MDH TST Documentation Requirements dated November 9, 2022, indicated at time of administration: - date and time test administered At time of reading: - date and time test read	{0 660}		

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{0 660}	Continued From page 5 - exact number of mm of induration (if no induration, document "0" mm) No further information was provided.	{0 660}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		

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{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

December 5, 2022

Administrator
American Eagle Owatonna
334 Cedardale Drive Southeast
Owatonna, MN 55060

RE: Initial License Number 409108
Health Facility Identification Number (HFID) 30559
Project Number(s) SL30559015

Dear Administrator:

On November 16, 2022, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the licensing evaluation completed August 12, 2022. The follow-up evaluation found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective **December 5, 2022**.

Furthermore, The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the August 12, 2022 initial evaluation.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on August 12, 2022, found not corrected at the time of the November 16, 2022 follow-up evaluation and subject to a penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
1290-Background Studies Required-144g.60 Subdivision 1 - $3,000.00
1530-Training In Dementia Care Required-144g.64

The details of the violations noted at the time of this follow-up evaluation completed on November 16, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint evaluation, and as otherwise needed. 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).

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order 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. 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 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 Casey DeVries, Supervisor, at 651-201-5917.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

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{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30559015-1 On November 15, 2022, through November 16, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 12, 2022. At the time of the survey, there were 14 residents; 13 of whom received services under the Assisted Living license. As a result of the revisit, the following orders were reissued. On November 22, 2022, an immediate correction order was re-issued for SL30559015-1, tag identification 1290. On November 22, 2022, the immediacy of correction order 1290 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: 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), which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of three employees (unlicensed personnel (ULP)-J). 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	{0 660}		

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{0 660}	Continued From page 2 situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment dated September 20, 2022, indicated a low risk level. ULP-J ULP-J had a hire date of September 9, 2022, to provide direct care services for residents under the licensee's Assisted Living license. ULP-J's employee record contained an undated Associate TB Surveillance Questionnaire; however, the record lacked evidence of completion of a first or second step of a two-step TST, or other evidence of TB screening such as a blood test. On November 16, 2022, at 1:39 p.m., assisted living director residency permit (ALDIR)-B stated ULP-J's record lacked evidence of TB screening as required, and stated she did not know how this was missed. The licensee's Tuberculosis Screening policy, dated September 27, 2022, indicated the licensee would establish and maintain a comprehensive TB infection control program according to the most current TB infection control guidelines issued by the CDC. The policy directed staff whose essential job functions require work within the same air space of home care clients, instead of assisted living residents, would be screened and tested for TB prior to the staff being exposed to clients. The policy also indicated new staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCW (health care workers), and would have a blood test or a two-step Mantoux (tuberculin skin test) conducted	{0 660}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30559	A. BUILDING: _____ B. WING _____	R 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 660}	Continued From page 3 with results documented, and no staff would be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux were read and documented in the employee medical file. MDH guideline, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guideline also 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 starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided.	{0 660}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	{0 790}		

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{0 790}	Continued From page 4 This MN Requirement is not met as evidenced by: No further action required.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	{0 810}		

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{0 810}	Continued From page 5 thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01290} SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	{01290}		

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{01290}	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of four employees (registered nurse (RN)-C). 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 has affected or has potential to affect a large portion or all of the residents). The findings include: RN-C obtained her RN license on October 20, 2016. RN-C was hired by the licensee on November 8, 2021, to provide supervision of staff and direct care services to the residents. RN-C's employee record contained a background study, submitted by a licensee with a different Health Facility Identification Number (HFID), previously operated by the same corporation, dated October 26, 2021. RN-C's employee record lacked evidence the licensee submitted a background study for their license and current HFID number. On November 15, 2022, at 10:00 a.m., assisted living director in residence (ALDIR)-B stated, although RN-C's background clearance letter listed the correct address of the facility, the name and HFID number affiliated with the clearance were from the licensee's previous comprehensive	{01290}	On November 22, 2022, the immediacy of correction order 1290 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	

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{01290}	Continued From page 7 license. ALDIR-B stated due to the licensee's administrative changes, the Minnesota Department of Human Services (DHS) NETStudy program was unable to affiliate RN-C with the licensee's current HFID number. ALDIR-B indicated they would need to contact DHS to correct this issue. The licensee's Background Studies policy, dated September 27, 2022, indicated the licensee would conduct a Minnesota DHS background study on all employees and volunteers and contractors, and no employee would provide direct services and independent direct contact with any residents until acceptable result of the background study had been received. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	{01290}		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another	{01530}		

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{01530}	Continued From page 8 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; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-I) received the required amount of dementia care training, in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee provided services under an assisted living license. During the entrance conference on November 15, 2022, at 9:30 a.m., assisted living director in residence (ALDIR)-B, registered nurse (RN)-C, and RN-L provided a current resident roster that indicated the licensee provided services to	{01530}		

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{01530}	Continued From page 9 residents with dementia and other related disorders. ULP-I ULP-I started employment on August 18, 2022, to provide assisted living services to the licensee's residents. ULP-I reached 160 working hours on October 20, 2022. ULP-I's record included a Relias (electronic training system) training transcript, indicating ULP-I had completed 2.75 hours of training in dementia care as of October 16, 2022, therefore less than the required 8 hours within 160 working hours. On November 16, 2022, at 10:40 a.m., ALDIR-B stated ULP-I lacked the required amount of initial training in dementia care and stated she had given ULP-I a deadline of November 30, 2022, to complete the training. The licensee's Dementia Training policy, dated September 27, 2022, indicated all staff were required to complete dementia training at the time of hire and annually thereafter, and direct care employees would complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided.	{01530}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

September 7, 2022

Administrator
American Eagle Owatonna
334 Cedardale Drive Southeast
Owatonna, MN 55060

RE: Conditional License Number SL30559015
Health Facility Identification Number (HFID) 30559
Project Number SL30559015

Dear Administrator:

The Minnesota Department of Health (MDH) completed a licensing evaluation on August 12, 2022. for the purpose of assessing compliance with state licensing statutes. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90 day conditional license due to expire on **December 6, 2022**.

In accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $6,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION
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.

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**.

Conditional License Issued:
MDH will issue American Eagle Owatonna a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if American Eagle Owatonna is in compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** American Eagle Owatonna will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. American Eagle Owatonna must provide the Department:

    i. A list of the names and birthdates of any individuals American Eagle Owatonna is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents by location including:
        1. Name and birthdate of each resident
        2. Physical location of each resident
        3. Current payment source for services
        4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** American Eagle Owatonna will contract with an RN to provide consultation concerning all resident(s) to whom American Eagle Owatonna provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from American Eagle Owatonna. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with American Eagle Owatonna and MDH must

review the RN's credentials and approve the selection. American Eagle Owatonna is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to American Eagle Owatonna in an effort to help American Eagle Owatonna align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. American Eagle Owatonna will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies American Eagle Owatonna and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at casey.devries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of American Eagle Owatonna to correct the violations cited during the evaluation as well as to determine the overall practice of American Eagle Owatonna in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. Corrective Action Plan: American Eagle Owatonna will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

Results of Follow-Up Survey During the Conditional License Period:
MDH will determine if American Eagle Owatonna is in compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines American Eagle Owatonna is in substantial compliance on the follow up evaluation, MDH will remove the conditions from American Eagle Owatonna's assisted living facility license, and American Eagle Owatonna will correct violations identified during the evaluation to come into full compliance. If MDH determines American Eagle Owatonna is not in substantial compliance, MDH may take additional enforcement action against American Eagle Owatonna, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

Request a Hearing:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing 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
Health.HRD.Appeals@state.mn.us

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

If you have any questions, please contact Casey DeVries directly at: 651-201-5917.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30559015-0 On August 8, 2022, through August 12, 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 15 residents, 13 of whom received services under the provider's Assisted Living license. An immediate correction order was identified on August 11, 2022, issued for SL30559015-0, tag identification 2310. On August 12, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at level 3, widespread scope. An immediate correction order was identified on August 12, 2022, issued for SL30559015-0, tag	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 identification 1290. On August 12, 2022, the immediacy of correction order 1290 was removed, however, non-compliance remained at level 3, widespread scope.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4;	0 250		

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0 250	Continued From page 2 (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 250		

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	30559	A. BUILDING: _____ B. WING _____	08/12/2022

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0 250	Continued From page 3 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference, via telephone, on August 8, 2022, at approximately 3:30 p.m., assisted living director residency permit (ALDRP)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota	0 250		

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0 250	Continued From page 4 Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G,	0 250		

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0 250	Continued From page 5 and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by Erin Trevino on July 15, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of November 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs,	0 250		

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0 250	Continued From page 6 including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - delegation of tasks by registered nurses or licensed health professionals; - supervision of registered nurses and licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. On August 12, 2022, at approximately 5:00 p.m., ALDRP-B and regional director of operations (RDO)-G confirmed the licensee provided orientation, training, and competency evaluations of staff, evaluated staff performance, conducted initial and ongoing resident evaluations and assessments of resident needs, orientation to and implementation of the assisted living bill or rights, delegation of tasks by the registered nurse (RN), supervision of the RN and licensed health professionals, and supervision of unlicensed personnel performing delegated tasks, but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued, 0250, 0320, 0470, 0500, 0510, 0550, 0640, 0660, 0680, 0730, 0790, 0800, 0810, 0900, 0910, 0920, 0930, 0940, 0970, 1290, 1440, 1470, 1530, 1560, 1620, 1640, 1650, 1690, 1700, 1730, 1780, 1790, 1920, 1930, 1940, 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95.	0 250		

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0 250	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 320 SS=F	144G.30 Subdivision 1 Regulatory powers (a) The Department of Health is the exclusive state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter. (b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to give access to relevant information during the survey process to determine compliance with licensure laws and rules. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 320		

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0 320	Continued From page 8 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). Findings include: On August 10, 2022, at approximately 8:45 a.m., the surveyors requested to review the licensee's policies and procedures. The binder with policies and procedures was provided at this time. On August 11, 2022, at approximately 3:30 p.m., after receiving an immediate correction order, regional director of operations (RDO)-G stated she was working on policies, because she was certain policies were missing from the binder that was given to surveyors. On August 12, 2022, at approximately 9:20 a.m., RDO-G verified the licensee did not have the all of the required policies, and stated the licensee utilized "best practice" guidelines that were kept in a separate binder; however, RDO-G refused the surveyor's access to the "best practice" guidelines binder. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 320		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at	0 470		

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0 470	Continued From page 9 least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required staffing plan was developed and posted, potentially affecting the licensee's 15 current residents, staff and any visitors of the licensee. 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	0 470		

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0 470	Continued From page 10 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a bed capacity of 20 residents and had a current census of 15 residents. STAFF POSTING During the entrance conference, via telephone, on August 8, 2022, at approximately 3:40 p.m., assisted living director residency permit (ALDRP)-B stated the staffing plan was developed, using staffing metrics, and staffing schedule was adjusted according to the census. The staffing schedule included two unlicensed personnel (ULP), registered nurse (RN)-C and ALDRP-B from 6:00 a.m., to 2:00 p.m., two ULP from 2:00 p.m., to 10:00 p.m., and one to two ULP, depending on census and acuity, from 10:00 p.m., to 6:00 a.m. On August 10, 2022, at approximately 8:40 a.m., upon arrival to the establishment, the surveyor observed the main entry area lacked the required posting of the daily staff schedule. The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each	0 470		

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0 470	Continued From page 11 building. On August 10, 2022, at approximately 8:55 a.m., ALDRP-B verified the monthly staff schedule was posted; however, the daily staffing schedule was not posted in a central location, as required. STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. On August 10, 2022, at approximately 8:55 a.m., ALDRP-B stated the licensee had no evidence of an evaluation for the appropriateness of the staffing levels in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of	0 500		

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0 500	Continued From page 12 maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks.	0 500		

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0 500	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference, via telephone, on August 8, 2022, at approximately 3:30 p.m., assisted living director residency permit (ALDRP)-B stated she reviewed the current assisted living regulations online. The licensee failed to ensure the following policies and procedures were in place and kept current: -conducting and handling background studies on employees; -orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; -conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how	0 500		

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0 500	Continued From page 14 changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; -orientation to and implementation of the assisted living bill of rights; -delegation of tasks by registered nurses or licensed health professionals; -supervision of registered nurses and licensed health professionals; and -supervision of unlicensed personnel performing delegated tasks. On August 12, 2022, at approximately 9:20 a.m., regional director of operations (RDO)-G verified the licensee did not have the policies listed above. RDO-G stated the licensee utilized "best practice" guidelines that were kept in a separate binder; however, RDO-G was not willing to provide those to surveyors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		
0 510 SS=F	144G.41 Subd. 3 Infection control program (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. (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. (c) The facility must maintain written evidence of	0 510		

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0 510	Continued From page 15 compliance with this subdivision. This MN Requirement is not met as evidenced by: 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 15 current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: PERSONAL PROTECTIVE EQUIPMENT (PPE) On August 10, 2022, at approximately 8:00 a.m., upon entering the facility, an unidentified staff member and assisted living director residency permit (ALDRP)-B greeted the surveyors in the common area, where the surveyors observed them to be wearing medical-grade facemasks, but no eye protection. ALDRP-B asked the surveyors to sign in and to complete a COVID-19 symptom questionnaire; however, there was no thermometer available to screen for fever. On August 10, 2022, at approximately 8:20 a.m., the surveyors were introduced to the regional director of operations (RDO)-G and registered	0 510		

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0 510	Continued From page 16 nurse (RN)-C, both of whom wore medical-grade masks, but no eye protection. On August 10, 2022, at approximately 8:50 a.m., the surveyors observed two unidentified male staff working in the kitchen and serving food to the residents, wearing medical-grade facemasks, but no eye protection. During an interview on August 10, 2022, at approximately 10:47 a.m., ALDRP-B stated the licensee stopped taking temperatures of staff and visitors in April 2022 because they received information that it was no longer necessary, and staff would only wear full PPE if there was a positive case of COVID-19 in the building, including eye protection. ALDRP-B stated, "It changed in April. We stopped doing that." On August 10, 2022, at approximately 12:35 p.m., the surveyor observed unlicensed personnel (ULP)-F push a resident in her wheelchair from the dining room to her room. ULP-F wore a medical-grade mask, but no eye protection. On August 10, 2022, at approximately 2:47 p.m., the surveyor observed ULP-H in R5's room, gathering her personal items, and then pushed R5 into the shower room across the hallway from her room to assist her with bathing. ULP-H wore a medical-grade mask, but no eye protection. During an interview on August 10, 2022, at approximately 3:00 p.m., ALDRP-B and RDO-G stated they were aware of the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker and the Minnesota Department of Health (MDH) PPE grid, available on the website; however, were not aware that they needed to review the community	0 510		

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	30559	A. BUILDING: _____ B. WING _____	08/12/2022

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0 510	Continued From page 17 transmission rates for their county. The surveyor showed ALDRP-B and RDO-G how to access this information. The community transmission rate in Steele County remained high, therefore, staff were required to wear eye protection when working with residents without suspected or confirmed COVID-19. 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), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection. The licensee's Personal Protective Equipment policy, dated February 28, 2020, directed staff who have contact with residents and/or their environment must wear PPE as appropriate during resident care activities, regardless of a resident's suspected or confirmed infection status. The policy also directed, staff should wear goggles or face shield when working with residents as added face/eye protection, and indicated personal eyeglasses were not a substitute for goggles. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 18 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's 15 current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the grievance procedure to include the name, telephone number and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for reporting	0 550		

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0 550	Continued From page 19 suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On August 10, 2022, at approximately 8:00 a.m., the surveyor observed the main entry area of the facility where there was a table with a visitor sign-in form and various postings. The surveyor observed grievance forms in a clear plastic stand-up document holder, however, did not observe the grievance procedure. On August 10, 2022, at approximately 8:40 a.m., during a tour of the facility with assisted living director residency permit (ALDRP)-B, the surveyor asked about the posting of the grievance procedure. ALDRP-B pulled the grievance procedure that was taped to the clear plastic stand-up document holder, behind the grievance forms, not conspicuously displayed as required. The grievance procedure directed the resident and/or the resident's responsible party to discuss the complaint with the associate and executive director; however, lacked contact information for the individual responsible for handing resident grievances, to include the name, telephone number, and email address. In addition, the grievance procedure included 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; however, lacked the contact information for reporting suspected maltreatment to MAARC, as required. On August 10, 2022, at approximately 8:42 a.m., ALDRP-B confirmed the required content noted above was not included.	0 550		

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0 550	Continued From page 20 The licensee's Grievances policy, undated, indicated each resident has the personal right to be informed by the administrator (or designated representative) of procedures to confidentially submit a complaint, including, but not limited to, the address and telephone number of the complaint receiving unit of the licensed agency. In addition, the policy lacked direction to post the grievance procedure in a conspicuous place, and lacked the requirement to post the required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to support protection and safety through access to the state's systems	0 640		

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0 640	Continued From page 21 for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all of the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to: -post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. On August 10, 2022, during the facility tour at approximately 8:40 a.m., the surveyor observed the entry area, common areas and medication rooms/charting areas within the facility and noted there was a posting in the medication storage room and in the nurse's office with information and the reporting number for MAARC; however, the information was not accessible to residents and/or their representatives. On August 10, 2022, at approximately 8:43 a.m., assisted living director residency permit (ALDRP)-B confirmed the MAARC information was not posted and available to residents, family members and visitors to the facility. The licensee's Abuse, Neglect and Exploitation	0 640		

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0 640	Continued From page 22 policy, undated, lacked direction to post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: 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), which included a current facility TB risk assessment, and completion of a two-step tuberculin skin test	0 660		

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0 660	Continued From page 23 (TST) or other evidence of TB screening such as a blood test, for one of four employees (registered nurse (RN)-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB FACILITY RISK ASSESSMENT During the entrance conference, via telephone, on August 8, 2022, at approximately 3:45 p.m., with assisted living director residency permit (ALDRP)-B and RN-C, the surveyor requested to review the facility TB risk assessment upon entrance to the facility. On August 11, 2022, at approximately 8:00 a.m., the surveyor again requested to review the licensee's TB Facility Risk Assessment. On August 12, 2022, at approximately 11:30 a.m., ALDRP-B stated the licensee had not completed a TB Facility Risk Assessment. TB SCREENING RN-C RN-C had a hire date of November 8, 2021, to provide supervision of staff and services for residents under the licensee's Assisted Living license.	0 660		

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0 660	Continued From page 24 RN-C's employee record contained a TB history and symptom screen completed on October 26, 2021; however, the record lacked evidence of completion of a first or second two-step TST. On August 12, 2022, at approximately 11:35 a.m., ALDRP-B confirmed RN-C's record lacked evidence of completed TSTs as required. The licensee's TB Infection Control Plan policy, date February 28, 2020, indicated a TB Risk Assessment, based on community/local/regional data, would be conducted annually for purposes of determining the community's TB risk classification and establishing controls. In addition, the policy indicated, "Residents and staff are tested for latent TB infection and screened for TB disease, if infected with TB." The policy did not include CDC or Minnesota Department of Health (MDH) accepted standard for baseline screening of health care workers prior to working with residents. MDH guideline, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guideline also 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 25 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to have a written	0 680		

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0 680	Continued From page 26 emergency preparedness (EP) plan with all of the required content and failed to provide building emergency exit diagrams to all residents. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the initial tour on August 10, 2022, at approximately 8:40 a.m., the surveyor observed the facility's layout included one large building with one level, with resident apartments. The main level included the main entrance, kitchen, dining room, several gathering spaces for residents and visitors, activity area and staff offices. A sign was posted in the common area regarding the licensee's emergency plan being available upon request. Although emergency exit diagrams were posted in the hallways, there was no evidence emergency exit diagrams were provided to the residents, as required. The EP plan, dated February 1, 2022, was located in a binder in the office adjacent the medication storage room. Assisted living director residency permit (ALDRP)-B stated the binder was accessible by all staff at all times. The Emergency Preparedness Plan lacked the following required content: - a comprehensive program to include infectious	0 680		

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0 680	Continued From page 27 diseases and pandemics; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies including surge planning and use of volunteers; - the facility's role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities, volunteers; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On August 12, 2022, at approximately 2:57 p.m., director of engineering (DOE)-A verified the above missing content, and verified emergency exit diagrams were not provided to residents, as required. No further information was provided.	0 680		

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0 680	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730		

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0 730	Continued From page 29 (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of one discharged resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included Parkinson's Disease, frequent falls, high blood pressure, major depressive disorder and type 2 diabetes. R1 began receiving services on March 7, 2019, and was discharged on February 5, 2022.	0 730		

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0 730	Continued From page 30 R1's service plan, dated December 14, 2021, indicated R1 received services including assistance with ambulating, bed mobility, toileting, medication management, blood glucose monitoring, bathing, dressing, housekeeping and laundry. R1's progress notes, dated February 2, 2022, indicated R1 would not be returning to the facility and would be admitted to a different facility upon discharge from the hospital. R1's record lacked evidence a discharge summary was completed. On August 10, 2022, at approximately 12:09 p.m., registered nurse (RN)-C stated R1 had a fall on January 27, 2022, while walking outside with her daughter and was hospitalized for injuries sustained from the fall. R1 did not return to the facility. RN-C stated her process when someone was discharged from the facility was to write a discharge note in the progress notes, document who accompanied the resident and where they were being discharged to, and the note would include a summary of the orders and a disposition of medications. The licensee's Move-Out policy, undated, indicated a "resident move-out summary" would be completed in the resident's record; however, the policy lacked direction regarding the required contents of the discharge summary. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30559	A. BUILDING: _____ B. WING _____	08/12/2022

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0 790	Continued From page 31	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain fire extinguishers in accordance to MNSFC provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On 08/10/2022 between 09:30 AM TO 11:30 AM, survey staff observed in the Mechanical Room and Sprinkler Riser Room that fire extinguishers were not located and hung on hangers	0 790		

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0 790	Continued From page 32 (DOA) A verbally confirmed survey staff observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the facility in good repair in regards to resident health and safety in accordance with maintenance and repair program. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 800		

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0 800	Continued From page 33 1. On 08/10/2022 between 09:30 AM TO 11:30 AM, survey staff observed in the B-Side Mechanical Room the storage of combustible materials within 30 inches of HVAC equipment 2. On 08/10/2022 between 09:30 AM TO 11:30 AM, survey staff observed in the NW Hall that the wall mounted emergency light fixture did not operate upon testing 3. On 08/10/2022 between 09:30 AM TO 11:30 AM, survey staff observed in Activities Storage Closet that ceiling tiles were missing 4. On 08/10/2022 between 09:30 AM TO 11:30 AM, survey staff observed in the Medical Supplies Storage Room that supplies were stacked and placed within 18 inches of sprinkler head(s) (DOA) A verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810		

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0 810	Continued From page 34 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed have detailed fire safety and evacuation plans and associated confirming documentation. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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).	0 810		

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0 810	Continued From page 35 Findings include: 1. On 08/10/2022 between 09:30 AM TO 11:30 AM, survey staff observed that no documentation was presented that clearly identified employee actions to be taken in the event of fire or similar 2. On 08/10/2022 between 09:30 AM TO 11:30 AM, survey staff observed that no documentation was presented to show fire protection procedures necessary for residents 3. On 08/10/2022 between 09:30 AM TO 11:30 AM, survey staff observed that evacuation maps mounted in hallways were incorrectly oriented to the true path of egress - identifying "up" as pathway 4. On 08/10/2022 between 09:30 AM TO 11:30 AM, survey staff observed that no documentation was presented to show that annual resident training on evacuation procedures and protocols is being completed 5. On 08/10/2022 between 09:30 AM TO 11:30 AM, survey staff observed that no documentation was presented to show that evacuation drills are being conducted 6. On 08/10/2022 between 09:30 AM TO 11:30 AM, survey staff observed that no documentation was presented to show that upon hire that staff are receiving training on fire safety and evacuation (DOA) A verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 900 SS=C	144G.50 Subdivision 1 Contract required (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. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (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. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (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. (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. This MN Requirement is not met as evidenced	0 900		

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0 900	Continued From page 37 by: Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract. This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete, unsigned copy of its contract as required. On August 12, 2022, at approximately 9:35 a.m., assisted living director residency permit (ALDRP)-B stated she was unable to confirm an unsigned copy of the licensee's contract had been sent to the Ombudsman as required. The licensee's Admission Agreement policy, undated, lacked direction to provide a complete, unsigned copy of its contract to the Office of Ombudsman for Long-Term Care, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		

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0 910	Continued From page 38	0 910		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R3) with records reviewed. 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). The findings include: The licensee lacked a written contract with the following required content: -the contract must include in a conspicuous place and manner on the contract the license number or Health Facility Identification (HFID) number of the facility;	0 910		

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0 910	Continued From page 39 -the contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: -the facility and contracted service provider when applicable; -the licensee of the facility; -the managing agent of the facility, if applicable; and -the authorized agent for the facility. R2's Residency and Services Agreement, dated August 1, 2021, indicated the licensee was registered by the State of Minnesota as a "Housing With Services establishment," and lacked the license number or HFID number. In addition, the agreement included the facility's address as "364 Cedardale Dr [drive] SE [southeast], Owatonna MN," instead of the correct address of 334 Cedardale Dr., Owatonna, MN. Further, the agreement did not include the name, telephone number, or the physical mailing address of the managing agent or the authorized agent. R3's Residency and Services Agreement, dated February 17. 2022, indicated the licensee was registered by the State of Minnesota as a "Housing With Services establishment," and lacked the license number or HFID number. In addition, the agreement included the facility's address as "364 Cedardale Dr SE, Owatonna MN," instead of the correct address of 334 Cedardale Dr., Owatonna, MN. Further, the agreement did not include the name, telephone number, or the physical mailing address of the managing agent or the authorized agent. On August 12, 2022, at approximately 8:45 a.m., regional director of operations (RDO)-G and assisted living director residency permit	0 910		

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0 910	Continued From page 40 (ALDRP)-B verified the contract lacked the license number and the correct address of the facility, and verified the agreement did not include any information regarding the management agent or the authorized agent of the facility. ALDRP-B verified the same contract was received by all residents living in the facility. The licensee's Admission Agreements policy, undated, did not address the required contents of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or	0 920		

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0 920	Continued From page 41 transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R2, R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 and R3's records lacked a written contract to include: - a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; and - a disclosure of the facility's ability to provide specialized diets. R2's Residency and Services Agreement, dated August 1, 2021, indicated the licensee was registered by the State of Minnesota as a "Housing With Services establishment," instead of an assisted living facility license. In addition,	0 920		

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0 920	Continued From page 42 the agreement lacked a disclosure of their ability to provide specialized diets. R3's Residency and Services Agreement, dated February 17, 2022, indicated the licensee was registered by the State of Minnesota as a "Housing With Services establishment," instead of an assisted living facility license. In addition, the agreement lacked a disclosure of their ability to provide specialized diets. On August 12, 2022, at approximately 8:30 a.m., regional director of operations (RDO)-G and assisted living director residency permit (ALDRP)-B confirmed the contracts lacked the above required content, and confirmed the contracts had the same content for all the licensee's residents. The licensee's Admission Agreements policy, undated, did not address the required contents of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the	0 930		

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0 930	Continued From page 43 termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R2, R3) with records reviewed. This had the potential to affect all 15 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 R2's care plan, dated June 15, 2022, indicated R2 received services including assistance with bathing, dressing, safety monitoring for fall risk, assistance with medical appointments, activities, housekeeping, nutrition monitoring and cognitive orientation.	0 930		

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0 930	Continued From page 44 R2's assisted living contract signed August 1, 2021, lacked the following content: -the name and contact information of the person representing the facility who is designated to handle and resolve complaints; -the right under section 144G.54 to appeal the termination of an assisted living contract; -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which a resident consent is required for a transfer; and -contact information for the Office of Ombudsman for Long-Term Care, Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. R3 R3's care plan, dated August 10, 2022, indicated R3 received assistance with bathing, toileting, dressing, oral care, safety monitoring for fall risk, assistance with medical appointments, activities, pain management, housekeeping and laundry. R3's assisted living contract signed February 17, 2022, lacked the following content: -the name and contact information of the person representing the facility who is designated to handle and resolve complaints; -the right under section 144G.54 to appeal the termination of an assisted living contract; -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which a resident consent is required for a transfer; and -contact information for the Office of Ombudsman for Long-Term Care, Ombudsman for Mental Health and Developmental Disabilities, and the	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30559	A. BUILDING: _____ B. WING _____	08/12/2022

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0 930	Continued From page 45 Office of Health Facility Complaints. On August 12, 2022, at approximately at 8:30 a.m., regional director of operations (RDO)-G and assisted living director residency permit (ALDRP)-B confirmed the contract lacked the required content as noted above, and confirmed the contract provided in the admission packet was the same contract used for all residents. The licensee's Admission Agreements policy, undated, did not address the required contents of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting	0 940		

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0 940	Continued From page 46 payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R3) with records reviewed. 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). The findings include: R2 and R3's records lacked a written contract to include: - whether the facility is enrolled with the	0 940		

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0 940	Continued From page 47 commissioner of human services to provide customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. R2's care plan, dated June 15, 2022, indicated R2 received services including assistance with bathing, dressing, safety monitoring for fall risk, assistance with medical appointments, activities, housekeeping, nutrition monitoring and cognitive orientation. R3's care plan, dated August 10, 2022, indicated R3 received assistance with bathing, toileting, dressing, oral care, safety monitoring for fall risk, assistance with medical appointments, activities, pain management, housekeeping and laundry.	0 940		

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0 940	Continued From page 48 On August 12, 2022, at approximately at 8:30 a.m., regional director of operations (RDO)-G and assisted living director residency permit (ALDRP)-B confirmed the contract lacked the required content as noted above, and confirmed the contract provided in the admission packet was the same contract used for all residents. The licensee's Admission Agreements policy, undated, did not address the required contents of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a	0 970		

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0 970	Continued From page 49 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: On August 11, 2022, at approximately 8:15 a.m., the surveyor requested a copy of the facility's assisted living contract. The licensee's Residency and Services Agreement (contract) included a clause on page 12, section B, "Risk Agreement. You are responsible for your personal, financial and health care decisions. You are also responsible for maintaining health, personal property, liability, automobile (if applicable), and other insurance coverages in adequate amounts. You agree to obtain insurance in an amount adequate to cover your personal property and your general liability. You acknowledge that we do not insure your person or property." In addition, on page 13, section 10, "You understand and agree to assume the risks inherent in this Agreement. You agree to hold us, our associates and agents harmless for any damages, injury or other loss resulting from: (1) reasonable acts or omissions made in good faith; (2) action by a third party, fire, water, theft or the elements; or (3) loss of personal property." On August 12, 2022, at approximately at 8:30 a.m., regional director of operations (RDO)-G and assisted living director residency permit (ALDRP)-B confirmed the contract included language waiving the facility's liability for health,	0 970		

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0 970	Continued From page 50 safety, or personal property of a resident, and confirmed the contract provided in the admission packet was the same contract used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies were conducted prior to staff providing services, for one of four employees (registered nurse (RN)-C) with employee records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01290	On August 12, 2022, the immediacy of correction order 1290 was removed, however, non-compliance remained at level 3, widespread scope.	

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01290	Continued From page 51 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 has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate correction order on August 12, 2022. The findings include: RN-C RN-C had a hire date of November 8, 2021. RN-C's employee record lacked evidence the licensee submitted a background study for RN-C. During an interview on August 8, 2022, at approximately 3:30 p.m., RN-C stated she provided care to the residents in the facility, supervised unlicensed staff, and provided education to staff. RN-C stated she remembered submitting the information for her background study, and recalled receiving an email indicating the information had been received; however, doesn't recall receiving a clearance letter. Throughout the course of the survey, August 10, 2022, through August 12, 2022, the surveyor observed RN-C having direct contact and conversations with residents in their private apartments and in common areas. On August 12, 2022, at approximately 12:19 p.m. licensed assisted living director (LALD)-B verified RN-C's record lacked a background study clearance.	01290		

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01290	Continued From page 52 The licensee's Associate Handbook, revised January 2021, indicated a criminal background check (and/or fingerprint clearance, if required by state or federal law) would be conducted on every associate who was offered a position. Also included, the offers of employment were conditional, pending results of a criminal or additional background investigation. Further, the handbook included, "You may not commence work in certain positions involving resident contact until the required criminal background check has been successfully completed." The licensee lacked a policy that addressed background studies. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (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 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. (b) The direct supervision of staff performing	01440		

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01440	Continued From page 53 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted supervision of unlicensed staff as required for two of two employees (unlicensed personnel (ULP)-E, ULP-F) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E was hired on February 15, 2022, to provide direct care services to residents of the assisted living facility. ULP-E's employee record included a 30-Day Supervision of Delegated Tasks form, noting "resident cares" were observed, and signed by RN-C on May 18, 2022, 92 days after the date that ULP-E began working for the facility. ULP-E's record lacked evidence an RN conducted direct supervision of ULP-E within 30 days of	01440		

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01440	Continued From page 54 performing delegated tasks. ULP-F ULP-F was hired on October 1, 2021, to provide direct care services to residents of the assisted living facility. ULP-F's employee record included a 30-Day Supervision of Delegated Tasks form, noting "resident cares" were observed, and signed by RN-C on November 29, 2021, 59 days after the date that ULP-F began working for the facility. ULP-F's record lacked evidence an RN conducted direct supervision of ULP-F within 30 days of performing delegated tasks. On August 12, 2022, at approximately 9:18 a.m., regional director of operations (RDO)-G and assisted living director residency permit (ALDRP)-B verified ULP-E and ULP-F's records lacked evidence of supervision within 30 days of performing delegated tasks. The licensee lacked a policy regarding supervision of unlicensed personnel performing delegated tasks; however, the Medication Technician Position Description, revised September 2018, included, "The position falls under the supervision of the Director of Assisted Living and/or Director of Memory Care but is expected to perform independently and exercise good judgement." In addition, the Caregiver Position Description, revised September 2018, included, "The position falls under the supervision of the LPN [licensed practical nurse]-Assisted Living and the Director of Assisted Living but is expected to perform independently and exercise good judgement." No further information was provided.	01440		

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01440	Continued From page 55 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (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; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (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 (9) a review of the types of assisted living services the employee will be providing and the	01470		

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01470	Continued From page 56 facility's category of licensure. (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 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: 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 three employees (registered nurse (RN)-C, unlicensed personnel (ULP)-E, ULP-F) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	01470		

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01470	Continued From page 57 of the residents). The findings include: RN-C, ULP-E and ULP-F's records lacked evidence to indicate the employees received orientation to include the required topics. RN-C RN-C started employment on November 8, 2021, to provide assisted living services to the licensee's residents, and to provide supervision of the licensee's employees. RN-C's record lacked the following required content: - an overview of 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; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - 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	01470		

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01470	Continued From page 58 - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-E ULP-E had a start date of February 15, 2022, to provide assisted living services to the licensee's residents. ULP-E's record lacked the following required content: - an overview of 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; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - 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 - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-F	01470		

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01470	Continued From page 59 ULP-F had a start date of October 1, 2021, to provide assisted living services to the licensee's residents. ULP-F's record lacked the following required content: - an overview of 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; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - 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 - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On August 12, 2022, at approximately 9:18 a.m., regional director of operations (RDO)-G and assisted living director residency permit (ALDRP)-B confirmed the above missing contents.	01470		

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01470	Continued From page 60 The licensee's Associate Training policy, undated, indicated direct care associates would receive initial orientation and ongoing in-service training based on state regulations and the needs of the residents being served in the community. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not 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	01530		

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01530	Continued From page 61 each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of four employees (unlicensed personnel (ULP)-E, ULP-F) received the required amount of dementia care training, in the required time frame with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee provided services under an assisted living license. During the entrance conference, via telephone, on August 8, 2022, at approximately 3:30 p.m., assisted living director residency permit (ALDRP)-B and registered nurse (RN)-C indicated the licensee provided services to residents with dementia and other related disorders. ULP-E ULP-E started employment on February 15, 2022, to provide assisted living services to the licensee's residents. ULP-E reached 160 working hours on March 18, 2022.	01530		

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01530	Continued From page 62 On August 10, 2022, at approximately 2:35 p.m., the surveyor observed ULP-E in R3's room conversing with the resident. R3's diagnoses included dementia, anxiety, major depressive disorder and repeated falls. ULP-E's record included a Relias training transcript, indicating ULP-E had completed 3.5 hours of training in dementia care as of March 18, 2022, therefore less than the required 8 hours within 160 working hours. ULP-F ULP-F started employment on October 1, 2021. ULP-F reached 160 working hours on November 7, 2021. On August 10, 2022, at approximately 12:35 p.m., the surveyor observed ULP-F assisting R3 from the dining room to her room after lunch. ULP-F's record included a Relias training transcript, indicating ULP-F had completed 2.5 hours of training in dementia care as of November 7, 2021, therefore less than the required 8 hours within 160 working hours. On August 12, 2022, at approximately 8:45 a.m., assisted living director residency permit (ALDRP)-B confirmed the employees lacked the required amount of initial training in dementia care. The licensee's Associate Training policy, undated, incorrectly included housing with services establishments that provide assisted living services under chapter 144G must meet the following training requirement: Direct care	01530		

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01530	Continued From page 63 employees would complete at least four hours of initial training within 160 hours of the employment start date and two hours of additional training for each 12 months of work thereafter. Further, required dementia training topics included an explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, and communication skills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01560		

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01560	Continued From page 64 licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: When interviewed on August 8, 2022, at approximately 3:30 p.m., assisted living director residency permit (ALDRP)-B and registered nurse (RN)-C indicated the licensee provided services to residents with dementia and other related disorders. On August 12, 2022, at approximately 8:45 a.m., ALDRP-B provided the surveyor with the licensee's Dementia Disclosure Statement, dated February 1, 2022, which indicated annual training was provided for employees, with training focused on various Alzheimer's and dementia care needs, including explanation of Alzheimer's and care needs, assistance and direction with providing care needs, problem solving with challenging behaviors, and communicating with individuals with dementia. The disclosure lacked the categories of employees trained, the frequency of training to include upon hire, and the basic topics covered to include person-centered	01560		

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01560	Continued From page 65 planning and service delivery. The licensee's Associate Training policy, undated, directed the licensee would provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a	01620		

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01620	Continued From page 66 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed resident reassessment and monitoring no more than 14 calendar days after initiation of services, and within 90 calendar days from the last date of the assessment using the uniform assessment tool for one of one resident (R3) as required, with records reviewed. In addition, the licensee failed to ensure the RN completed a reassessment based on changes in the needs of the resident using the uniform assessment tool for one of one resident (R2), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 8, 2022, at approximately 3:51 p.m., during the entrance conference via telephone, RN-C stated her understanding was assessments should be completed upon admission, then a review was conducted 30 days after admission, and then every 90 days thereafter, or sooner if there was a significant change in the resident's condition.	01620		

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01620	Continued From page 67 R3 R3 was admitted for services on February 18, 2022. R3's diagnoses included dementia, muscle weakness, repeated falls, major depressive disorder, anxiety, high blood pressure and obesity. R3's care plan, dated August 10, 2022, indicated R3 received assistance with bathing, toileting, dressing, oral care, safety monitoring for fall risk, assistance with medical appointments, activities, pain management, housekeeping and laundry. On August 11, 2022, at approximately 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R3's medications. R3's record included an initial assessment titled, Greenbrier Evaluation-V6, dated February 18, 2022, March 23, 2022 (33 days later), and June 23, 2022 (92 days later). R3's record lacked a reassessment and monitoring no more than 14 calendar days after initiation of services and within 90 calendar days from the last date of the assessment, as required. In addition, the Greenbrier Evaluation-V6 form did not include spiritual and cultural preferences, review of medications, or a list treatments including type, frequency and level of assistance needed. R2 R2 was admitted for services on December 21, 2017. R2's diagnoses included type 2 diabetes, high blood pressure, osteoarthritis, pain left ankle, and urinary tract infection diagnosed July 12, 2022.	01620		

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01620	Continued From page 68 R2's care plan, dated June 15, 2022, indicated R2 received services including assistance with bathing, dressing, safety monitoring for fall risk, assistance with medical appointments, activities, housekeeping, nutrition monitoring and cognitive orientation. On August 11, 2022, at approximately 10:10 a.m., the surveyor observed R2 sitting in her room. R2's record included a 90-day reassessment titled, Greenbrier Evaluation-V6, dated June 21, 2022. Although R2 was hospitalized on July 12, 2022, and returned to the facility on July 27, 2022, with medication changes including the addition of insulin and changes in the needs of the resident, R2's record lacked a reassessment. In addition, the Greenbrier Evaluation-V6 form did not include spiritual and cultural preferences, review of medications, or list treatments including type, frequency and level of assistance needed. On August 12, 2022, at approximately 10:40 a.m., RN-C verified the above assessments were not completed timely per the regulations and confirmed the assessment tool was a template that was used for all residents. The licensee's Ongoing Resident Assessments policy, undated, indicated residents were assessed/evaluated on an ongoing basis, and would be formally assessed thirty days after admission, and on a quarterly basis, at which time the administrator/assisted living director would consult with the caregivers and associates to ensure the resident's needs were met. The policy lacked direction with the correct timeline for resident reassessment and monitoring per the regulations.	01620		

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01620	Continued From page 69 The licensee's Change in Condition policy, undated, indicated when a resident displayed a change in condition, caregivers were directed to notify the administrator/assisted living director. The policy lacked any direction that a reassessment should be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 70 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current written service plan was revised to reflect the current services provided for two of two residents (R2, R3), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 11, 2022, at approximately 11:50 a.m., registered nurse (RN)-C and assisted living director residency permit (ALDRP)-B referred to the licensee's Greenbrier Evaluation-V6, included in the electronic medical record, as the assessment template used for initial assessment and subsequent reassessments. In addition, RN-C and ALDRP-B identified the same document as the service plan, and stated the residents' required services were documented in the assessment and were reviewed with the resident and/or their representative, and then was signed by the resident and RN-C, to agree to the services. R2 and R3's service plan lacked revision to reflect the current services each received. R2	01640		

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01640	Continued From page 71 R2 was admitted for services on December 21, 2017, and received services under the licensee's assisted living license. R2's diagnoses included type 2 diabetes, high blood pressure, osteoarthritis, pain left ankle, and urinary tract infection diagnosed July 12, 2022. R2's care plan, dated June 15, 2022, indicated R2 required assistance with bathing, dressing, safety monitoring for fall risk, assistance with medical appointments, activities, housekeeping, nutrition monitoring and cognitive orientation. On August 11, 2022, at approximately 10:10 a.m., the surveyor observed R2 sitting in her chair in her room. R2's prescriber orders, dated July 27, 2022, indicated R2 required assistance to put on her TED (compression) stockings in the morning, and to take them off in the evening. In addition, the orders directed to check R2's blood sugar as needed for dizziness, change of condition, and to evaluate for low blood sugars, and to give Lantus (long-acting insulin) 100 unit/milliliter (ml), inject 30 units subcutaneously (under skin) at bedtime for diabetes. R2's Greenbrier Evaluation-V6, dated June 21, 2022, intended as R2's 90-day reassessment and service plan, included R2's orientation status, medical diagnoses review, allergies, code status, recent hospitalizations, psycho-social management, medications and treatments, health observations, nutritional management, and addressed R2's need for assistance with activities of daily living and life enrichment. Under the Medications & Treatments section, RN-C noted R2 required medication management, and	01640		

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01640	Continued From page 72 indicated R2 required "Basic medication program," which included oral medications, noncomplex patches, creams, metered dose inhalers without the need for nebulizer treatments, instead of, the "Extensive Medication program," which included blood glucose monitoring, insulin and injections. The reassessment/service plan did not include R2's need for TED stockings. The reassessment/service plan was signed and dated on June 22, 2022, by R2 and RN-C. On August 12, 2022, at approximately 9:40 a.m., RN-C stated R2 was hospitalized July 12, 2022, and stated her reassessment/service plan should have been updated when she returned so that the current services would be reflected on the service plan. R3 R3 was admitted on February 18, 2022, and received services under the licensee's assisted living license. R3's diagnoses included dementia, muscle weakness, repeated falls, major depressive disorder, anxiety, high blood pressure and obesity. R3's care plan, dated August 10, 2022, indicated R3 received assistance with bathing, toileting, dressing, oral care, safety monitoring for fall risk, assistance with medical appointments, activities, pain management, housekeeping and laundry. On August 11, 2022, at approximately 8:45 a.m., the surveyor observed while unlicensed personnel (ULP)-D administered R3's medications.	01640		

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	30559	A. BUILDING: _____ B. WING _____	08/12/2022

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01640	Continued From page 73 R3's Treatment Administration Record, dated July 1, 2022, through July 31, 2022, indicated R2 required TED stockings applied to both lower extremities in the morning and removed before bed. R3's Greenbrier Evaluation-V6, dated June 23, 2022, intended as R3's 90-day reassessment and service plan, included R3's orientation status, medical diagnoses review, allergies, code status, recent hospitalizations, psycho-social management, medications and treatments, health observations, nutritional management, and addressed R3's need for assistance with activities of daily living and life enrichment. Under the Medications & Treatments section, RN-C noted R3 required medication management, and indicated R3 required daily weights; however, lacked R3's need for TED stockings. The reassessment/service plan was signed and dated on June 23, 2022, by R3 and RN-C. On August 12, 2022, at approximately 9:44 a.m., RN-C verified the current services should be reflected on the service plan. The licensee's Service Plans policy, undated, directed a resident-centered service plan was created and maintained for every resident and should address activities of daily living, medication management and/or assistance required, physical needs related to illness/chronic disease management, psychosocial needs including activities, behavioral challenges/needs, spiritual needs, fall history and/or risk, nutritional needs, skin integrity issues, any need identified by the family or resident, activities, and transportation needs. A current copy of the service plan, signed by the resident and/or responsible party should be retained in the	01640		

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01640	Continued From page 74 resident record. The policy also directed formal review would take place 30 days after admission, quarterly, annually, and upon significant change in the resident status. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and	01650		

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01650	Continued From page 75 declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 11, 2022, at approximately 11:50 a.m., registered nurse (RN)-C and assisted living director residency permit (ALDRP)-B referred to the licensee's Greenbrier Evaluation-V6, included in the electronic medical record, as the assessment templated used for initial assessment and subsequent reassessments, and as the service plan, and stated the residents' required services were documented in the assessment and reviewed with the resident and/or their representative, and then was signed by the resident and RN-C, to agree to the services. R2 and R3's service plans lacked the following required content: - the identification of staff or categories of staff who will provide the services;	01650		

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01650	Continued From page 76 - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; and - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. R2's Greenbrier Evaluation-V6, dated June 21, 2022, intended as R2's 90-day reassessment and service plan, included R2's orientation status, medical diagnoses review, allergies, code status, recent hospitalizations, psycho-social management, medications and treatments, health observations, nutritional management, and addressed R2's need for assistance with activities of daily living and life enrichment. The reassessment/service plan was signed and dated on June 22, 2022, by R2 and RN-C. The reassessment/service plan lacked the content noted above. R3's Greenbrier Evaluation-V6, dated June 23, 2022, intended as R3's 90-day reassessment and service plan, included R3's orientation status, medical diagnoses review, allergies, code status, recent hospitalizations, psycho-social management, medications and treatments, health observations, nutritional management, and addressed R3's need for assistance with activities of daily living and life enrichment. Under the Medications & Treatments section, RN-C noted	01650		

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01650	Continued From page 77 R3 required medication management, and indicated R3 required daily weights; however, lacked R3's need for TED stockings. The reassessment/service plan was signed and dated on June 23, 2022, by R3 and RN-C. The reassessment/service plan lacked the content noted above. On August 12, 2022, at approximately 9:50 a.m., RN-C verified the service plan lacked the required content and stated the same reassessment/service plan was utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides 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. (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	01690		

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01690	Continued From page 78 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. This MN Requirement is not met as evidenced by: 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). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 8, 2022, at approximately 3:40 p.m., RN-C and assisted living director residency permit	01690		

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01690	Continued From page 79 (ALDRP)-B confirmed the licensee provided medication management services to the licensee's residents. The licensee lacked the following required policies: - preparing and giving medications; and - verifying that prescription drugs are administered as prescribed. On August 12, 2022, at approximately 8:40 a.m., regional director of operations (RDO)-G confirmed the licensee lacked the above noted policies and stated the "best practice" procedures likely included the information; however, RDO-G was not willing to provide those to surveyors. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01690		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications,	01700		

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01700	Continued From page 80 allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for two of two residents (R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 8, 2022, at approximately 3:40 p.m., registered nurse (RN)-C and assisted living director residency permit (ALDRP)-B confirmed the licensee provided medication management services to the licensee's residents.	01700		

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01700	Continued From page 81 R2 R2's record lacked evidence the RN had conducted a medication assessment to include: - identification and review of all medications the resident is known to be taking; - must be conducted face to face; - indications for medications; - side effects; - contraindications; and - identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. R2's care plan, dated June 15, 2022, indicated R2 required assistance with bathing, dressing, safety monitoring for fall risk, assistance with medical appointments, activities, housekeeping, nutrition monitoring and cognitive orientation. The care plan lacked information regarding R2's need for medication management. R2's prescriber orders, dated July 27, 2022, included one pain reliever, two medications to decrease blood pressure, one insulin, two supplements, eye drops and ointments. R2's Medication Administration Record (MAR), dated July 1, 2022, through July 31, 2022, and August 1, 2022, through August 10, 2022, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. R2's Greenbrier Evaluation-V6, dated June 21,	01700		

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01700	Continued From page 82 2022, intended as R2's 90-day reassessment and service plan, under the Medications & Treatments section, RN-C noted R2 required medication management; however, did not include the above required content. R3 R3's record lacked evidence the RN had conducted a medication assessment to include: - identification and review of all medications the resident is known to be taking; - must be conducted face to face; - indications for medications; - side effects; - contraindications; and - identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On August 11, 2022, at approximately 8:45 a.m., the surveyor observed while unlicensed personnel (ULP)-D administered R3's medications. R3's care plan, dated August 10, 2022, indicated R3 received assistance with bathing, toileting, dressing, oral care, safety monitoring for fall risk, assistance with medical appointments, activities, pain management, housekeeping and laundry. The care plan lacked information regarding R3's need for medication management. R3's prescriber orders, dated July 6, 2022, included two inhalers, one medication to decrease water retention, two antidepressants,	01700		

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01700	Continued From page 83 one pain reliever, a supplement, one medication to treat high blood pressure, and one medication to treat high cholesterol. R3's MAR, dated July 1, 2022, through July 31, 2022, and August 1, 2022, through August 10, 2022, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. R3's Greenbrier Evaluation-V6, dated June 23, 2022, intended as R3's 90-day reassessment and service plan, under the Medications & Treatments section, RN-C noted R3 required medication management; however, did not include the above required content. On August 10, 2022, at approximately 12:09 p.m., RN-C confirmed the assessments lacked the above required content. The licensee's Day of Admission/Move-In policy, undated, indicated "The administrator coordinates and delegates (to the ALD) the following on move-in day to ensure appropriate resident care." Under Medications, the policy directed, "All new prescriptions are sent to the pharmacy for same day delivery, or if using existing refills, medications are verified...The medication cart/storage area is labeled and organized...The MAR (Medication Assistance Record) is set up, including resident photograph in place." The policy lacked direction to ensure the RN conducted an individualized medication assessment with the required content. The licensee's Resident Arrives with Medications policy, undated, indicated when a resident arrives at the facility with medications, steps will be taken	01700		

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01700	Continued From page 84 to ensure proper storage and handling of the medication. Also included, "The Assisted Living Director discusses medications with the resident or the responsible party." The policy lacked direction to ensure the RN conducted an individualized medication assessment with the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed	01730		

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01730	Continued From page 85 personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management plan prior to providing medication management services, and with the required content, for two of two residents (R2, R3), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 8,	01730		

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01730	Continued From page 86 2022, at approximately 3:40 p.m., registered nurse (RN)-C and assisted living director residency permit (ALDRP)-B confirmed the licensee provided medication management services to the licensee's residents. R2 R2's record lacked a medication management plan to include the following required content: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. R2 was admitted for services on December 21, 2017, and received services under the licensee's assisted living license. R2's diagnoses included type 2 diabetes, high blood pressure, osteoarthritis, pain left ankle, and urinary tract infection diagnosed July 12, 2022.	01730		

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	30559	A. BUILDING: _____ B. WING _____	08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	334 CEDARDALE DRIVE SE OWATONNA, MN 55060

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01730	Continued From page 87 R2's care plan, dated June 15, 2022, indicated R2 required assistance with bathing, dressing, safety monitoring for fall risk, assistance with medical appointments, activities, housekeeping, nutrition monitoring and cognitive orientation. The care plan lacked information regarding R2's need for medication management. R2's prescriber orders, dated July 27, 2022, included one pain reliever, two medications to decrease blood pressure, one insulin, two supplements, eye drops and ointments. R2's Medication Administration Record (MAR), dated July 1, 2022, through July 31, 2022, and August 1, 2022, through August 10, 2022, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. R2's Greenbrier Evaluation-V6, dated June 21, 2022, intended as R2's 90-day reassessment and service plan, under the Medications & Treatments section, RN-C noted R2 required medication management. R2's record lacked an individualized medication management plan that included the above content. R3 R3's record lacked a medication management plan to include the following required content: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01730		

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01730	Continued From page 88 - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. R3 was admitted on February 18, 2022, and received services under the licensee's assisted living license. R3's diagnoses included dementia, muscle weakness, repeated falls, major depressive disorder, anxiety, high blood pressure and obesity. On August 11, 2022, at approximately 8:45 a.m., the surveyor observed while unlicensed personnel (ULP)-D administered R3's medications. R3's care plan, dated August 10, 2022, indicated R3 received assistance with bathing, toileting, dressing, oral care, safety monitoring for fall risk, assistance with medical appointments, activities, pain management, housekeeping and laundry. The care plan lacked information regarding R3's need for medication management.	01730		

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01730	Continued From page 89 R3's prescriber orders, dated July 6, 2022, included two inhalers, one medication to decrease water retention, two antidepressants, one pain reliever, a supplement, one medication to treat high blood pressure, and one medication to treat high cholesterol. R3's MAR, dated July 1, 2022, through July 31, 2022, and August 1, 2022, through August 10, 2022, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. R3's Greenbrier Evaluation-V6, dated June 23, 2022, intended as R3's 90-day reassessment and service plan, under the Medications & Treatments section, RN-C noted R3 required medication management. On August 10, 2022, at approximately 12:09 p.m., RN-C verified R2 and R3's records lacked an individualized medication management plan with the above required content. The licensee lacked a policy regarding ensuring development of an individualized medication management plan prior to providing medication management services, and with the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will	01780		

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01780	Continued From page 90 (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement policies and procedures for giving accurate and current medications for those residents who received medication management services during planned times away from home. This had the potential to affect all 13 residents receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference via telephone on August 8, 2022, at approximately 3:40 p.m., registered nurse (RN)-C and assisted living director residency permit (ALDRP)-B confirmed	01780		

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01780	Continued From page 91 the licensee provided medication management services to 13 of the licensee's residents. On August 11, 2022, at approximately 9:10 a.m., RN-C stated unlicensed personnel (ULP)were responsible for giving residents or their representatives medications when the resident was going to be absent from the facility during a scheduled medication administration time, whether it was planned or unplanned time away from the facility. RN-C further stated she wasn't sure if there was a written procedure developed for the ULP when providing medications to the resident or their representative for time away from the facility; however, they were trained to do so. On August 12, 2022, at approximately 9:20 a.m., regional director of operations (RDO)-G and assisted living director residency permit (ALDRP)-B verified the policies provided were the policies staff used to direct their care of the residents, and stated they had "best practice" procedures; however, RDO-G was not willing to provide those to surveyors. RDO-G verified the policy for medication management for the residents during planned time away did not include the required information. The licensee's Transferring Medications for Home Visits and Outings policy, undated, included "Associate will assist resident to obtain/maintain necessary medications for use while not in the community." The procedure did not differentiate whether the time away from the facility was planned or unplanned, and who was responsible to provide the medications for each. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01780		

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01780	Continued From page 92 days	01780		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (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; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (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. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (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 (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: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to	01790		

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01790	Continued From page 93 be provided; (iv) how the unlicensed staff must document in 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; (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; (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 (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. This MN Requirement is not met as evidenced by: 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, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01790		

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01790	Continued From page 94 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference via telephone on August 8, 2022, at approximately 3:40 p.m., registered nurse (RN)-C and assisted living director residency permit (ALDRP)-B confirmed the licensee provided medication management services to 13 of the licensee's residents. The licensee's Transferring Medication for Home Visits and Outings policy, undated, did not differentiate planned or unplanned time away from the facility, and noted when a resident left the facility for a short period of time during which only one dose of medication was needed, the "Designated associate person" would give the medications to the responsible party in an envelope (or similar container) labeled with the resident's name, name of the medication(s), and instructions for administering the dose. The procedure further directed, if the resident was to be gone for more than one dosage period, the designated associate person may give the full prescription container to the resident, or responsible party, or have the pharmacy fill a separate prescription or separate the existing prescription into two bottles, or the resident's family could obtain a separate supply of the medication for use when the resident visited family. Also included, the designated associate person reviewed the resident's physician orders and service plan to verify the ability of the resident to store and self-administer medications while away from he community. If it was not safe to give the medications to the resident, the medications were entrusted to the person whom	01790		

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01790	Continued From page 95 was escorting the resident out of the facility. The person entrusted with the medications agreed in writing as to the amount of medication received on behalf of the resident and the appropriate dosing amount and schedule. The licensee's procedure lacked the following: - 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; - a review by the RN of the completion of this task to verify the task was completed accurately by the unlicensed personnel (ULP); and - 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. On August 11, 2022, at approximately 9:10 a.m., RN-C stated ULP were responsible for giving residents or their representatives medications when the resident was going to be absent from the facility during a scheduled medication administration time, whether it was planned or unplanned time away from the facility. RN-C further stated she wasn't sure if there was a written procedure developed for the ULP when providing medications to the resident or their representative for time away from the facility; however, they were trained to do so. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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01920	Continued From page 96	01920		
01920 SS=F	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement procedures for loss and spillage of all controlled substances defined in Minnesota Rules part 6800.4220. 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:	01920		

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01920	Continued From page 97 During the entrance conference, via telephone, on August 8, 2022, at approximately 3:40 p.m., registered nurse (RN)-C confirmed the licensee provided medication management services to residents, including storage of controlled substances. On August 11, 2022, at approximately 9:28 a.m., the surveyor observed the licensee's secure storage of controlled substances with unlicensed personnel (ULP)-D. On August 12, 2022, at approximately 8:35 a.m., regional director of operations (RDO)-G and assisted living director residency permit (ALDRP)-B stated the licensee did not have a procedure for loss or spillage of controlled substances, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or	01930		

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01930	Continued From page 98 prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference via telephone on August 8, 2022, at approximately 3:40 p.m., assisted living director residency permit (ALDRP)-B and RN-C confirmed the licensee provided treatment management services. The surveyor requested to review the licensee's policies and procedures upon entrance to the facility.	01930		

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01930	Continued From page 99 The provided policies and procedures failed to address: - monitoring and evaluating the treatment or therapy. On August 12, 2022, at approximately 8:45 a.m., regional director of operations (RDO)-G confirmed the licensee lacked the above required policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and	01940		

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01940	Continued From page 100 (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: During the entrance conference via telephone on August 8, 2022, at approximately 3:48 p.m., registered nurse (RN)-C stated the licensee provided treatment management services to residents, including oxygen, compression stockings, blood glucose checks and modified diets. R2 R2's record lacked a treatment management plan to include the following required content:	01940		

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	30559	A. BUILDING: _____ B. WING _____	08/12/2022

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AMERICAN EAGLE OWATONNA	334 CEDARDALE DRIVE SE OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 101 - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R2 was admitted for services on December 21, 2017, and received services under the licensee's assisted living license. R2's diagnoses included type 2 diabetes, high blood pressure, osteoarthritis, pain left ankle and urinary tract infection. R2's prescriber orders, dated July 27, 2022, indicated R2 required assistance to put on TED (compression) stockings in the morning, and to take them off in the evening. In addition, the orders directed to check R2's blood sugar as needed for dizziness, change of condition and to evaluate for low blood sugars. R2's care plan, dated June 15, 2022, indicated R2 required assistance with bathing, dressing, safety monitoring for fall risk, assistance with medical appointments, activities, housekeeping, nutrition monitoring and cognitive orientation. R2's care plan did not address her compression	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30559	A. BUILDING: _____ B. WING _____	08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	334 CEDARDALE DRIVE SE OWATONNA, MN 55060

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01940	Continued From page 102 stockings or blood sugar checks. R2's Greenbrier Evaluation-V6, dated June 21, 2022, intended as R2's 90-day reassessment and service plan, included "Medications & Treatments;" however, the only question regarding therapy or treatment included whether or not the resident was undergoing chemotherapy, radiation therapy or dialysis therapy. The reassessment/service plan did not include R2's need for TED stockings or blood glucose monitoring. The reassessment/service plan was signed and dated on June 22, 2022, by R2 and RN-C. R3 R3's record lacked a treatment management plan to include the following required content: - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R3 was admitted on February 18, 2022, and received services under the licensee's assisted living license. R3's diagnoses included dementia, muscle weakness, repeated falls, major depressive disorder, anxiety, high blood pressure and obesity.	01940		

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	30559	A. BUILDING: _____ B. WING _____	08/12/2022

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01940	Continued From page 103 R3's care plan, dated August 10, 2022, indicated R3 received assistance with bathing, toileting, dressing, oral care, safety monitoring for fall risk, assistance with medical appointments, activities, pain management, housekeeping and laundry. The care plan lacked direction for compression stockings. R3's Treatment Administration Record, dated July 1, 2022, through July 31, 2022, indicated R2 required TED stockings applied to both lower extremities in the morning and removed before bed. R3's Greenbrier Evaluation-V6, dated June 23, 2022, intended as R2's 90-day reassessment and service plan, included "Medications & Treatments;" however, the only question regarding therapy or treatment included whether or not the resident was undergoing chemotherapy, radiation therapy or dialysis therapy. The reassessment/service plan did not include R2's need for TED stockings or blood glucose monitoring. The reassessment/service plan was signed and dated on June 23, 2022, by R3 and RN-C. On August 12, 2022, at approximately 9:40 a.m., RN-C verified R2 and R3 lacked a treatment or therapy management plan that included the above content, as required. The licensee lacked a policy regarding the development and implementation of a treatment or therapy management plan for each resident receiving management of ordered or prescribed treatments or therapy services, to include the required content. No further information was provided.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30559	A. BUILDING: _____ B. WING _____	08/12/2022

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01940	Continued From page 104 TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (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. This MN Requirement is not met as evidenced by: 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 two of three residents (R2, R4) with an assistive device attached to their beds. 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 has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate correction order on August 11, 2022. The findings include: R2 On August 10, 2022, at approximately 8:15 a.m., licensed assisted living director (LALD)-B	02310	On August 12, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at level 3, widespread scope.	

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	30559	A. BUILDING: _____ B. WING _____	08/12/2022

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02310	Continued From page 105	02310		

provided surveyors with a current resident roster that indicated no residents in the facility had siderails. When interviewed at 2:00 p.m., registered nurse (RN)-C indicated one resident (R3) had an assistive device attached to her bed, and provided a siderail assessment, risks versus benefits documentation, and manufacturer's instructions for installation. RN-C stated there were no other siderails or assistive devices in the facility.

Review of R2's record, indicated R2 had diagnoses including type 2 diabetes, recent urinary tract infection diagnosed July 12, 2022, after a fall, pain in left ankle, osteoarthritis, and bilateral cataracts.

R2's Greenbrier Evaluation-V6, dated June 21, 2022, indicated R2 was oriented, required total assistance with bathing, assistance with dressing and grooming, toileting, escorts to and from meals and activities in wheelchair, and medication management.

On August 11, 2022, at approximately 10:05 a.m., during review of R2's Individual Abuse Prevention Plan (IAPP), dated June 22, 2022, RN-C indicated R2 had siderails/bed mobility devices.

On August 11, 2022, at approximately 10:06 a.m., the surveyor observed R2's bed had bilateral assistive devices on the upper portion of her bed. The devices were round, approximately 11.5 inches in diameter, with seven small openings. The devices were attached to the bed frame with one bolt on each side, with a metal bar under the bedspring, extending from one side of the bed to the other. Each device had a metal bar that extended from the circle device to the floor, with a metal platform on the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30559	A. BUILDING: _____ B. WING _____	08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	334 CEDARDALE DRIVE SE OWATONNA, MN 55060

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02310	Continued From page 106 During an interview on August 11, 2022, at approximately 10:10 a.m., RN-C stated she was unaware that R2 had assistive devices on her bed, and the surveyors accompanied RN-C to R2's room. R2 indicated the devices had been on her bed since she moved into the facility in 2017. R2 stated she uses the devices all the time to get in and out of bed and to turn from side to side while in bed, and stated "they are my lifeline." R2 stated she had the manufacturer's instructions for a long time, but thinks the housekeepers threw them away. On August 11, 2022, at approximately 11:03 a.m., RN-C stated she had been employed with the licensee since November 2021, and stated she had not assessed the siderails because she was unaware that R2 had devices on her bed. RN-C stated she was unable to locate a siderail assessment or risk versus benefits for R2's devices. R4 Upon observation of R4's room on August 11, 2022, at approximately 11:06 a.m., with RN-C, R4's bed had an assistive device attached to the left side of her twin sized bed. RN-C stated she was unaware that R4 had a device on her bed, and stated one of family members must have brought it in. R4 stated her husband had used the device for 15 to 20 years, and her family brought it in for her to use here at the facility, sometime in May 2022. RN-C was observed to measure the device, which was approximately 33 1/4 inches in length, extending from the head of bed to the middle of the bed. The device had four horizontal bars with three openings, that extended the full length of the device. RN-C lifted the mattress, and the device had a u-shaped metal bar that	02310		

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02310	Continued From page 107 was slid between the mattress and the box spring. The device was slightly movable and could be shifted when grasped. R4 was admitted to the facility on May 19, 2022, and had diagnoses including artificial left knee device, diarrhea, blood clots, congestive obstructive pulmonary disease, chronic kidney disease, osteoporosis, gout, and depression. R4's Greenbrier Evaluation-V6, dated May 12, 2022, indicated R4 was oriented, required assistance with bathing, assistance with dressing and grooming, toileting, laundry and housekeeping, and uses a four wheeled walker for ambulation. R4's IAPP, undated, indicated R4 did not have assistive devices on her bed. On August 11, 2022, at approximately 11:55 a.m., RN-C stated R4's record lacked a siderail assessment, risks versus benefits, and/or manufacturer's directions to ensure correct installation of the device. RN-C stated she did not know when the device was placed on R4's bed because she sits on her bed and visits with her weekly, and had not noticed the device. RN-C stated she needed to educate staff to alert her when devices were placed on resident's beds so that she could complete an assessment. The licensee's Corporal Punishment and Restraints policy, undated, directed, "Bedrails are not permitted." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated "licensees should refer to individual	02310		

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02310	Continued From page 108 manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

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

Type: Full
Date: *08/10/22*
Time: 08:53:13
Report: 8044221224

Food and Beverage Establishment Inspection Report

Location:
Timberdale Trace Assisted Livi
334 Cedardale Drive SE
Owatonna, MN55060
Steele County, 74

Establishment Info:
ID #: 0010884
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
American Eagle Owatonna AL LLC

Phone #: 5074468600
ID #: 52283

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = 166.5 at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Spray bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 164.5 Degrees Fahrenheit - Location: Sausage links
Violation Issued: No

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

Process/Item: Hot Holding
Temperature: 40.1 Degrees Fahrenheit - Location: Chicken pot pie in upright
Violation Issued: No

Process/Item: Hot Holding
Temperature: 39.7 Degrees Fahrenheit - Location: Hamburger patty in upright
Violation Issued: No

Type: Full
Date: *08/10/22*
Time: 08:53:13
Report: 8044221224
Timberdale Trace Assisted Livi

Food and Beverage Establishment Inspection Report

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

Inspection conducted during HRD survey with lead Nurse Evaluator LoAnn DeGange'.

Establishment Info: bblouin@timberdaletrace.org
rmajeed@timberdaletrace.org

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 8044221224 of 08/10/22.

Certified Food Protection Manager: Brittany L. Blouin

Certification Number: FM76510 Expires: 03/02/24

Signed: _____
Inspector signed for Brittany

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