DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery
January 19, 2023

Licensee
Arbor Garden Place
535 Canyon Drive Northwest
Eyota, MN 55934

RE: Initial License Number 408480
Health Facility Identification Number (HFID) 30217
Project Number(s) SL30217015

Dear Licensee:

On January 10, 2023, 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 September 30, 2022.

The follow-up evaluation determined your facility had not fully corrected all of the state licensing orders issued pursuant to the September 30, 2022, initial evaluation. However, your facility has achieved substantial compliance. Based on these findings, the condition(s) on the license were removed effective January 19, 2023.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on September 30, 2022, found not corrected at the time of the January 10, 2023 follow-up evaluation and subject to a penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b)

The details of the violations noted at the time of this follow-up evaluation completed on January 10, 2023 (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 are assessed.

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).

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

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 Jodi Johnson directely at: 507-344-2730.

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	R 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(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 SL30217015-1 On January 9, 2023, through January 10, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 30, 2022. At the time of the survey, there were 33 residents: 32 who were receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action requried.	{0 480}		
{0 660} SS=E	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.	{0 660}		

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{0 660}	Continued From page 2 (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 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 TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for four of four employees (unlicensed personnel (ULP)-M, ULP-E, ULP-L, ULP-D). 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's TB facility risk assessment dated September 15, 2022, indicated the licensee was a low risk. ULP-M ULP-M was hired June 6, 2022, to provide direct care services. ULP-M's employee record contained a Baseline TB Screening Tool for Health Care Workers dated June 6, 2022, October 5, 2022, November 11, 2022, and a first step TST administered	{0 660}		

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{0 660}	Continued From page 3	{0 660}		

November 11, 2022. The first step TST was read November 14, 2022. ULP-M's employee file lacked evidence of a second TST and results.

ULP-E
ULP-E was hired April 21, 2022, to provide direct care services.

ULP-E's employee record contained a Baseline TB Screening Tool for Health Care Workers dated July 26, 2022, November 15, 2022, and a first step TST administered July 26, 2022. The TST had an interpretation of reading documented as negative, although the form lacked the date of the reading or millimeters of induration. ULP-E had a first step TST administered November 15, 2022. The first step TST was read on November 17, 2022. ULP-E's employee file lacked evidence of a second TST and results.

ULP-L
ULP-L was hired September 15, 2022, to provide direct care services.

ULP-L's employee record contained a Baseline TB Screening Tool for Health Care Workers dated September 19, 2022, November 11, 2022, and a first step TST administered September 19, 2022. The first step TST was read on September 21, 2022. ULP-L's record further contained a TST administered on November 10, 2022, (over seven weeks later) at 6:00 p.m. The TST was read on November 14, 2022, at 10:55 a.m. (88 hours and 55 minutes later).

ULP-D
ULP-D was hired February 1, 2022, to provide direct care services.

ULP-D's employee record contained a Baseline

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{0 660}	Continued From page 4 TB Screening Tool for Health Care Workers dated September 28, 2022, November 15, 2022, and a first step TST administered September 28, 2022. The first step TST was read on September 30, 2022. ULP-D's record further contained a TST administered on November 15, 2022, (almost six weeks later) and read November 18, 2022. On January 10, 2022, at 11:48 a.m. registered nurse (RN)-I verified the above findings. RN-I indicated a non-nursing personnel had overseen auditing and scheduling the required TST's. RN-I further stated moving forward it would be a nursing only task. 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 Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents 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	{0 660}		

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{0 660}	Continued From page 5 employee's record." The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, identified new employees would have a baseline screening for TB according to current CDC recommendations and guidelines. No further information was provided.	{0 660}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	{0 780}		

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{0 780}	Continued From page 6 by: No further action required.	{0 780}		
{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}	Continued From page 7	{0 810}		
{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}		

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{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations contained all the required training for two of four unlicensed personnel (ULP-M, ULP-D). 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:	{01380}		

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{01380}	Continued From page 9 ULP-M ULP-M had a hire date of June 6, 2022, and started providing services under the licensee's assisted living with dementia care. ULP-M's employee record lacked evidence of training to include the following required content: - recognizing physical, emotional, cognitive, and developmental needs of the client. ULP-D ULP-D had a hire date of February 1, 2022, and started providing services under the licensee's assisted living with dementia care license. ULP-D's employee record lacked evidence of training to include the following required content: -recognizing physical, emotional, cognitive, and developmental needs of the resident. On January 10, 2023, at 3:17 p.m. licensed assisted living director (LALD)-A verified the above topic was lacking from ULP-M and ULP-D's employee files. LALD-A indicated both employees had completed the licensee's on-line training and not the paper packet which specifically included the training. On January 10, 2023, at 4:15 p.m. registered nurse (RN)-I verified ULP-M and ULP-D's records lacked the above-named training content. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, included: 6. Training and competency evaluations for unlicensed personnel providing assisted living services must include: d. recognizing physical, emotional, cognitive, and developmental needs of the resident.	{01380}		

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{01380}	Continued From page 10 No further information was provided.	{01380}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

October 27, 2022

Administrator
Arbor Garden Place
535 Canyon Drive Northwest
Eyota, MN 55934

RE: Conditional License Number 408480
Health Facility Identification Number (HFID) 30217
Project Number(s) SL30217015

Dear Administrator:

The Minnesota Department of Health (MDH) completed a licensing evaluation on September 30, 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 **January 25, 2023**.

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 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $9,000.00. 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), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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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.

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul,MN551640970
Health.HRD.Appeals@state.mn.us

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 Arbor Garden Place 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 Arbor Garden Place 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: Arbor Garden Place will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. Arbor Garden Place must provide the Department:

i. A list of the names and birthdates of any individuals Arbor Garden Place 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: Arbor Garden Place will contract with an RN to provide consultation concerning all resident(s) to whom Arbor Garden Place provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Arbor Garden Place. 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. The RN must not have any affiliation with Arbor Garden Place and MDH must review the RN's credentials and approve the selection. Arbor Garden Place is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Arbor Garden Place in an effort to help Arbor Garden Place 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. Arbor Garden Place 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 Arbor Garden Place and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jodi.johnson@state.mn.us. Jodi Johnson can be reached at 507-344-2730 (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 Arbor Garden Place to correct the violations cited during the evaluation as well as to determine the overall practice of Arbor Garden Place 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: Arbor Garden Place 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 Arbor Garden Place 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 Arbor Garden Place is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Arbor Garden Place's assisted living facility license, and Arbor Garden Place will correct violations identified during the evaluation to come into full compliance. If MDH determines Arbor Garden Place is not in substantial compliance, MDH may take additional enforcement action against Arbor Garden Place, 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 Jodi Johnson directly at: 507-344-2730.

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	09/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30217015 On September 25, 2022 through September 30, 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 35 residents; 30 of which were receiving services under the provider's Assisted Living with Dementia Care license. 2310: An immediate correction order was issued on September 27, 2022. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (I). 1290: An immediate correction order was issued on September 28, 2022. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (I).	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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0 250	Continued From page 1	0 250		
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; (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;	0 250		

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0 250	Continued From page 2 (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 when the managerial officials who oversaw the day-to-day operations and attested they understood applicable statutes and rules, failed to implement current policies and procedures as required. 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 entrance conference on September 26, 2022, at approximately 11:15 a.m., licensed	0 250		

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0 250	Continued From page 3 assisted living director (LALD)-A and registered nurse (RN)-B stated they 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 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	0 250		

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0 250	Continued From page 4	0 250		

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, 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

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0 250	Continued From page 5 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 the licensee on May 26, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of June 30, 2023. The licensee failed to ensure the following policies and procedures were implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - 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	0 250		

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0 250	Continued From page 6 and Prevention standards; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; - supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued: 0630, 0660, 1290, 1370, 1380, 1440, 1460, 1540, 1620, 1710, 1750, 1770, 1880, 1890, 1910, 1940, 1960, 1970, and 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 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
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 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,	0 470		

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0 470	Continued From page 7 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 as required, potentially affecting the licensee's 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 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 with dementia care license. The facility was licensed for a bed capacity of 60 residents and had a current census of 35 residents. The licensee lacked a daily staffing schedule	0 470		

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0 470	Continued From page 8 developed by the clinical nurse supervisor and failed to develop and implement a staffing plan for determining its staffing level that: - 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; - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building; - 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. During the entrance conference on September 26, 2022, at approximately 11:15 a.m. the licensee's staffing plan was requested. On September 26, 2022, at approximately 11:58 a.m. registered nurse (RN)-B provided the surveyor a facility tour. The main entry and common areas were observed to include various required postings including the licensee's license, grievance procedure, contact information for the Ombudsman, electronic monitoring sign, Minnesota Adult Abuse Reporting Center numbers, and activities. However, no daily staffing schedule was posted as required. RN-B verified the finding at this time.	0 470		

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0 470	Continued From page 9 On September 27, 2022, at approximately 9:30 a.m. licensed assisted living director (LALD)-A confirmed a staffing plan had not been developed or a schedule posted as required. LALD-A indicated he was aware of the requirement but was on his second week of employment and did not realize it was missing at the facility. The licensee's 2.03 Staffing & Scheduling policy dated August 1, 2021, identified the clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The clinical nurse supervisor would develop a 24-hour daily staffing schedule that would identify: a. direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked, and b. the direct-care staff member's resident assignments or work location In addition, the policy identified the daily work schedule would be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 10 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 27, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 485	Continued From page 11	0 485		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post a menu a week in advance that was made available to all residents. 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	0 485		

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	30217	A. BUILDING: _____ B. WING _____	09/30/2022

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0 485	Continued From page 12 or has potential to affect a large portion or all of the residents). The findings include: On September 27, 2022, at 11:33 a.m. during observation of the noon meal service in the assisted living dining room, the current lunch meal was posted on a white board hanging on a wall in dining room. No other menu postings were observed. On September 27, 2022, at 11:47 a.m. R2 indicated none of the residents know what the menu is for each meal until the day of. On September 27, 2022, at 11:50 a.m. R7 and R1 stated it "bothers us" that the menu is not posted ahead of time. R7 and R1 further indicated management was aware that residents wanted a posted menu and had been told they were working on it weeks ago, but still had not followed through. On September 27, 2022, at 11:53 unlicensed personnel (ULP)-F verified no menu is posted except for the current meal they are receiving. On September 27, 2022, at 11:56 dietary manager (DM)-G verified the menu is not posted or made available to the residents in advance. DM-G stated after breakfast, he posts the noon meal on the white board, and after the noon meal, the evening meal is posted on the white board. DM-G indicated he was aware of the regulation for a weekly menu being posted, and indicated it was something they were working on getting done. On September 27, 2022, at 12:25 p.m. licensed	0 485		

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0 485	Continued From page 13 assisted living director (LALD)-A verified the menu was not posted and indicated he was aware of the requirement. The licensee's 12.01 Food Service & Menu Planning policy dated August 1, 2021, included menus would be prepared at least one week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a	0 630		

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0 630	Continued From page 14 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: R1, R2, and R3's records lacked an individual abuse prevention plan to include an assessment of the resident's susceptibility to abuse by other individuals. R1 R1 began receiving assisted living services on April 19, 2022. R1's unsigned and untitled document identified as the service plan per facility staff, last reviewed September 26, 2022, indicated R1 received services that included bathing assistance three times weekly, medication administration, and blood glucose checks as prescribed. On September 27, 2022, at 10:33 a.m. unlicensed personnel (ULP)-D was observed to check R1's blood sugar and administer oral medications. R1's Vulnerable Adult/Individual Abuse Prevention Assessment2 form dated April 19, 2022, included R1's risk of abusing other vulnerable adults and statement of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. However, the report lacked an assessment of R1's susceptibility to abuse by another individual, including other	0 630		

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0 630	Continued From page 15 vulnerable adults. R2 R2 began receiving assisted living services on August 3, 2021. R2's unsigned and untitled document identified as the service plan per facility staff, last reviewed November 22, 2021, indicated R2 received services that included medication administration and medication set up by nurse each week On September 27, 2022, at 1:30 p.m. ULP-D was observed to administer oral medications to R2. R2's Vulnerable Adult/Individual Abuse Prevention Assessment2 form dated June 3, 2022, included R2's risk of abusing other vulnerable adults and statement of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. However, the report lacked an assessment of R2's susceptibility to abuse by another individual, including other vulnerable adults. R3 R3 began receiving assisted living services on August 1, 2021. R3's service plan signed on July 29, 2021, indicated that R3 received services that included medication management, daily grooming assistance and weekly bathing assistance. On September 28, 2022, at 8:00 a.m. ULP-D was observed to administer oral medications to R3. R3's Vulnerable Adult/Individual Abuse Prevention Assessment2 form dated April 29, 2022, included	0 630		

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0 630	Continued From page 16 R3's risk of abusing other vulnerable adults and statement of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. However, the report lacked an assessment of R3's susceptibility to abuse by another individual, including other vulnerable adults. On September 29, 2022, at approximately 1:08 p.m., registered nurse (RN)-I confirmed the resident records lacked the above required content, and stated the same format was utilized for all residents. RN-I further stated there had been a form update some time ago and the language was removed at that time. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1, 2021, noted [The Licensee] would develop individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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	0 660		

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0 660	Continued From page 17 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 observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screen for one of two employees (unlicensed personnel (ULP)-D) and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for two of two employees (ULP-D, ULP-E). 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's TB facility risk assessment dated September 15, 2022, indicated the licensee was a low risk.	0 660		

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0 660	Continued From page 18 ULP-D ULP-D was hired February 1, 2022, to provide direct care services. On September 27, 2022, at 1:20 p.m. ULP-D was observed to administer oral medications to R2. ULP-D's employee record lacked evidence of the following: - TB history and symptom screening; and - TB screening ULP-E ULP-E was hired April 21, 2022, to provide direct care services. On September 26, 2022, at 3:00 p.m. ULP-E was observed to verbally interact with R3 alone in her room. ULP-E's employee record contained a TB history and symptom screening dated July 26, 2022. The form included ULP-E received a first step TST on July 26, 2022, with an interpretation of reading documented as negative, although the form lacked the date of the reading or millimeters of induration. The form further lacked a second TST and results. On September 28, 2022, at 3:00 p.m. licensed assisted living director (LALD)-A verified ULP-D and ULP-E's employee files lacked the above TB requirements. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, identified new employees would have a baseline screening for TB according to current CDC recommendations and guidelines.	0 660		

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0 660	Continued From page 19 The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents 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." 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.	0 680		

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0 680	Continued From page 20 (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 interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all 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 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 September 29, 2022, at 5:13 p.m. the surveyor reviewed the emergency preparedness plan and Appendix Z with licensed assisted living director (LALD)-A. The licensee's EP plan consisted of several documents and policies, dated 2020. The plan included a hazard and vulnerability assessment and various policies/procedures.	0 680		

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0 680	Continued From page 21 The licensee's plan lacked the following required content: - Maintain emergency preparedness plan and update annually; - EP program patient population; - Process for EP collaboration with local, tribal, regional, State and Federal EP officials/organizations; -Development of all policies/procedures for: -Provision of subsistence needs for staff and residents; -Tracking of staff and residents; -Sheltering in place; -Medical documents; -Use of volunteers; -Arrangement with other facilities and providers to receive residents; -Roles under a 1135 waiver declared by the Secretary; -Methods for sharing information; -Sharing information on occupancy/needs; -LTC family notifications; - Emergency prep training and testing; - Emergency prep training program; - Emergency prep testing requirements On September 29, 2022, at 5:13 p.m. LALD-A confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z to include the above requirements. LALD-A indicated he was aware of the emergency preparedness requirements, but he had only worked in this role for the last two weeks stating, "what you see is what we have". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 730	Continued From page 22	0 730		
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; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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0 730	Continued From page 23 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 observation, interview and record review, the licensee failed to ensure the resident record included documentation of wound measurements and medication changes for one of three residents (R3). In addition, the licensee failed to ensure a discharge summary with the required content was included for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3 diagnoses included Parkinson's disease (a disease of the nervous system that affects movement, often including tremors), Lewy Body dementia (a type of dementia that affects the brain's ability to effectively problem solve and	0 730		

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0 730	Continued From page 24 reason), hallucinations and history of lower extremity blood clots. R3's service plan/care plan integrated into registered nurse (RN) assessment revised April 29, 2022, indicated R3 received services that included medication management and indicated that "communicating with the prescriber(s) and the pharmacy will be done by the community staff". R3's MAR dated September 2022, indicated hydrocortisone cream was started on May 15, 2022, with direction to apply topically twice daily to the affected area on bottom until healed and continue to offload the area, but lacked any nursing/progress notes that indicated a wound had developed and lacked an assessment or measurements. On August 15, 2022, R3 had a wound care appointment with the wound clinic. This appointment was managed by R3's daughter. On August 16, 2022, R3's progress notes, as triggered by the licensee's electronic medical records system, indicated a possible drug to drug interaction with a new order that was received. The order was sent by R3's provider on August 15, 2022, for amoxicillin 875 milligrams (mg) two times daily for seven days for wound healing. R3's record lacked evidence of discussion with R3's provider regarding the possible drug to drug interaction or the wound appointment that occurred on August 15, 2022. On September 28, 2022, at approximately 9:20 a.m. the surveyor asked licensed practical nurse	0 730		

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0 730	Continued From page 25 (LPN)-C for more information/documentation regarding R3's wound care appointment on August 15, 2022. LPN-C was unable to find any written information from that appointment and placed a call to the wound clinic for documentation/orders created the day of the appointment. On September 28, 2022, at approximately 9:10 a.m. LPN-C stated that she looked at R3's wound on August 15, 2022, after R3 returned from the wound clinic and measured it but failed to document it in R3's record. On September 28, 2022, at approximately 4:30 p.m. LPN-C stated that she looked at R3's wound just now and it looked "100% better" than the last time she saw it. R3's record lacked any documentation of wound measurements or wound condition completed by the licensee's nursing staff. On September 29, 2022, at approximately 1:45 p.m. registered nurse (RN)-I reviewed the documentation and confirmed the lack of measurements and nursing documentation. RN-I stated her expectation was the licensee's nurses would complete and document weekly wound measurements. DISCHARGE SUMMARY R4 R4's record indicated that R4 had start of services dated October 5, 2015, and was discharged on August 8, 2022. R4 had diagnoses that included Alzheimer's disease and heart disease.	0 730		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 26 R4's progress note electronically written on August 8, 2022, by RN-B indicated "the resident was discharged today to [nursing home] for a higher level of care. Current supply of medications were sent. She had been receiving hospice services but was discharged from [hospice agency] as R4 no longer met qualifications for services. Most recently was being followed by the Care Transitions (Mayo Clinic) team. R4 required two assist with transfers and was mobile via broda chair due to poor trunk control. R4 had advanced Alzheimer's disease. R4 was dependent on staff for all of her personal cares and ancillary tasks. Her son managed her finances." R4's record lacked the required content for a discharge summary to include: -a summary of the resident's stay that included diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent labs, radiology and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable that included the resident status, including baseline and current mental, behavioral, and functional status On September 27, 2022, at approximately 3:15 p.m. RN-B stated there was "some sharing of information over the period of weeks with the receiving facility regarding R4's move to their facility." RN-B stated she was not aware of the required documentation that came with a resident's discharge from an assisted living facility. RN-B stated she had been working off of a discharge form that was built into their electronic records system and would need to	0 730		

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0 730	Continued From page 27 have someone update the form to include the new requirements. No further information provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 28 by: Based on observation and interview, the licensee failed to confirm the age and interconnectivity of smoke alarm devices in resident sleeping areas and apartments 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: 1. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed discoloration of smoke alarms in resident apartments, no documentation was available to confirm the age or date of manufacture of the residential devices 2. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed and testing of smoke alarms that the residential devices were not interconnected between the bedroom(s) and the common area of the apartment (DM)-K and (LALD) A verbally confirmed survey staff observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		

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0 790	Continued From page 29	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 confirm inspection and maintenance of 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 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed on the main floor in the dementia unit of the facility that a fire extinguisher	0 790		

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0 790	Continued From page 30 located in the common area did not have an inspection tag on the device (DM)-K and (LALD) 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	0 800		

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0 800	Continued From page 31 a large portion or all of the residents). Findings include: 1. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed during the walk-through of the structure that in the 2nd floor staff office an air conditioning unit was connected to a power-strip 2. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed during the walk-through of the structure that multi-tap adapters were in use in the Activities Area and the Dementia Care Unit 3. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed during the walk-through of the structure that the 2nd FL hallway closet had items stacked and stored within 18 inches of the fire sprinkler head 4. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed during the walk-through of the structure that the on the 1st FL the hallway emergency light did not function upon testing 5. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed during the walk-through of the structure that the on the 1st FL in the garbage chute discharge room that the chute self-closing or auto-closing hardware appeared to be non-functional 6. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed during the walk-through of the structure that the on the 1st FL in the laundry room adjacent to the kitchen that the washing machine was connected to a	0 800		

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0 800	Continued From page 32 power-strip 7. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed during the walk-through of the structure that the on the 1st FL in the dining room area that the furniture configuration was obstructing clear access to an exit 8. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed during the walk-through of the structure that the on the 1st FL in the kitchen and serving kitchen area that sprinkler heads were covered with foreign substances and/or exhibiting signs of oxidation 9. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed during the walk-through of the structure that the on the 1st FL in kitchen the 6-burner + oven commercial range was outfitted with a commercial exhaust hood, but there was no evidence of an automatic fire extinguishment system (DM)-K and (LALD) 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;	0 810		

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0 810	Continued From page 33 (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: 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	0 810		

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0 810	Continued From page 34 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: 1. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed that no documentation was presented to confirm that evacuation plan addressed unique and unusual resident needs in the event of an evacuation 2. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed that no documentation was presented to show that annual resident training on evacuation procedures and protocols is being completed 3. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed that no documentation was presented to show that fire drill and/or evacuation drills are being conducted 4. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed that no documentation was presented to show that upon hire and twice annually thereafter that staff are receiving training on fire safety and evacuation 5. On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed during documentation review of the fire safety and evacuation plan that staff identified that at present there was only a single location of the documentation and that staff may or may not know the location (DM)-K and (LALD) A verbally confirmed	0 810		

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0 810	Continued From page 35 survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	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	0 900		

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0 900	Continued From page 36 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 by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract prior to providing assisted living services for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 began receiving assisted living services on April 19, 2022. R1's unsigned and untitled document identified as the service plan per facility staff, last reviewed September 26, 2022, indicated R1 received services that included bathing assistance three times weekly, medication administration, and blood glucose checks as prescribed. On September 27, 2022, at 10:33 a.m. unlicensed personnel (ULP)-D was observed to check R1's blood sugar and administer oral medications. R1's record lacked evidence an assisted living	0 900		

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0 900	Continued From page 37 contract was received by R1. On September 28, 2022, at 11:33 a.m. licensed assisted living director (LALD)-A verified R1 lacked a contract. LALD-A indicated he was aware of the requirement but was on his second week of employment and did not realize R1 was without a contract. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 1, 2021, indicated when a prospective resident decides to move into [The Licensee] a signed assisted living contract must be signed and received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
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 38 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure background studies were conducted prior to staff providing services for one of two employees (unlicensed personnel (ULP-E) with records reviewed. This had the potential to affect all residents currently receiving services. This resulted in an immediate correction order on September 28, 2022, at 1:08 p.m. 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: The licensee lacked evidence a background study had been completed prior to ULP-E providing direct care and services to the licensee's residents. ULP-E began providing direct care services for the licensee on April 21, 2022. On September 26, 2022, at 3:00 p.m. ULP-E was observed to verbally interact with R3 alone in her room. On September 28, 2022, at 1:00 p.m. licensed assisted living director (LALD)-A stated there was not a background study clearance form in ULP-E's employee file. LALD-A stated the	01290		

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01290	Continued From page 39 background study information was completed in the new hire paperwork, then it was forwarded to someone at the corporate level to process the background study. LALD-A stated he is aware of the background study clearance letter requirement but was not aware ULP-E did not have a background study clearance, noting he had only worked in this role for the last two weeks. The licensee's 5.05 Background Studies policy dated August 1, 2021, identified no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by the surveyor's on-site observation and review by evaluation supervisor on September 28, 2022, at 5:30 p.m.; however, noncompliance remains at a scope and severity of I. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition	01370		

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ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(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
01370	Continued From page 40 to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01370	Continued From page 41 two unlicensed personnel (ULP-D, ULP-E). 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: ULP-D and ULP-E's record lacked evidence of the following education and/or competencies had been completed prior to providing direct cares: - documentation requirements for all services provided; - reports of changes in the client's condition to the supervisor designated by the provider; - maintenance of a clean and safe environment; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and clients and the client's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices.	01370		

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01370	Continued From page 42 ULP-D had a hire date of February 1, 2022, and started providing services under the licensee's Assisted Living with Dementia Care. On September 27, 2022, at 1:20 p.m. ULP-D was observed to administer oral medications to R2. ULP-D's employee record lacked evidence of the above required training. ULP-E had a hire date of April 21, 2022, and started providing services under the licensee's Assisted Living with Dementia Care. On September 26, 2022, at 3:00 p.m. ULP-E was observed to verbally interact with R3 alone in her room. ULP-E's employee record lacked evidence of the above required training. On September 29, 2022, at 3:06 p.m. registered nurse (RN)-I verified the above topics were lacking from ULP-D and ULP-E's employee file. RN-I indicated required courses were automatically assigned, but neither employee had completed them. The licensee's 5.09 Employee Files policy dated August 1, 2021, noted employee records for each person would include records of all training and in-service education required and/or provided including record of competency testing as requested. The licensee's 5.10 Training Records policy dated August 1, 2021, noted [The Licensee] would maintain a record of staff training and competency required.	01370		

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01370	Continued From page 43 The licensee's 6.14 Delegation of Assisted Living Services dated August 1, 2021, noted a RN or licensed health professional at [The Licensee] may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The policy further identified a RN could delegate nursing services to a person who has successfully completed staff orientation, who has been trained in the service to be provided, and who has demonstrated to the RN the ability to competently follow the procedures for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as	01380		

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01380	Continued From page 44 required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure training and competency evaluations contained all the required training for two of two unlicensed personnel (ULP-D, ULP-E). 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: ULP-D's employee record lacked evidence to indicate the employee's completed training and/or practical skills evaluations as required in the following areas prior to providing direct care services: - observation, reporting, and documenting of client status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the client; and - range of motioning and positioning. ULP-D had a hire date of February 1, 2022, and started providing services under the licensee's Assisted Living with Dementia Care.	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01380	Continued From page 45 On September 27, 2022, at 1:20 p.m. ULP-D was observed to administer oral medications to R2. ULP-D's employee record lacked evidence of the above required training. ULP-E's employee record lacked evidence to indicate the employee's completed training and/or practical skills evaluations as required in the following areas prior to providing direct care services: - observation, reporting, and documenting of client status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the client. ULP-E had a hire date of April 21, 2022, and started providing services under the licensee's Assisted Living with Dementia Care. On September 26, 2022, at 3:00 p.m. ULP-E was observed to verbally interact with R3 alone in her room. ULP-E's employee record lacked evidence of the above required training. On September 29, 2022, at 3:06 p.m. registered nurse (RN)-I verified the above topics were lacking from ULP-D and ULP-E's employee files. RN-I indicated required courses were automatically assigned, but neither employee had completed them. The licensee's 5.09 Employee Files policy dated	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01380	Continued From page 46 August 1, 2021, noted employee records for each person would include records of all training and in-service education required and/or provided including record of competency testing as requested. The licensee's 5.10 Training Records policy dated August 1, 2021, noted [The Licensee] would maintain a record of staff training and competency required. The licensee's 6.14 Delegation of Assisted Living Services dated August 1, 2021, noted a RN or licensed health professional at [The Licensee] may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The policy further identified a RN could delegate nursing services to a person who has successfully completed staff orientation, who has been trained in the service to be provided, and who has demonstrated to the RN the ability to competently follow the procedures for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	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	01440		

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01440	Continued From page 47 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 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of two of two unlicensed personnel (ULP-D, ULP-E) performing delegated nursing or therapy tasks within 30 days of first providing those 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, 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:	01440		

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01440	Continued From page 48 On September 27, 2022, at 1:20 p.m. ULP-D was observed to administer oral medications to R2. ULP-D was hired on February 1, 2022, to provide direct care services to residents at the assisted living. ULP-D's employee record lacked documentation of a RN supervising ULP-D performing delegated tasks within 30 days of beginning work with the licensee. ULP-E was hired on April 21, 2022, to provide direct care services to residents at the assisted living. ULP-E's employee record lacked documentation of a RN supervising ULP-E performing delegated tasks within 30 days of beginning work with the licensee. On September 29, 2022, at 2:49 p.m. RN-I confirmed both ULP-D and ULP-E provided delegated tasks and verified their employee files lacked a 30-day supervision of delegated tasks. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated August 1, 2021, noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [The Licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance. The policy further identified documentation of supervision activities would be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

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01460	Continued From page 49	01460		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two employees unlicensed personnel (ULP-D, ULP-E) received orientation to assisted living facility licensing requirements and regulations before providing 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, 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: ULP-D ULP-D was hired February 1, 2022, to provide direct care services. On September 27, 2022, at 1:20 p.m. ULP-D was	01460		

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01460	Continued From page 50 observed to administer oral medications to R2. ULP-D's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - 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-E ULP-E was hired on April 21, 2022, to provide assisted living services.	01460		

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01460	Continued From page 51 On September 26, 2022, at 3:00 p.m. ULP-E was observed to verbally interact with R3 alone in her room. ULP-E's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - 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.	01460		

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01460	Continued From page 52 On September 28, 2022, at approximately 3:00 p.m. licensed assisted living director (LALD)-A confirmed the above missing orientation components of the employee files. LALD-A indicated they had online education in place to meet the requirement but neither employee had completed it. LALD-A further identified he was in his second week of employment and not sure how the education and completion was tracked for employees. The licensee's 5.09 Employee Files policy dated August 1, 2022, noted employee records for each person would include verification of completed orientation and annual training and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01460		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not 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	01540		

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01540	Continued From page 53 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 observation, interview and record review, the licensee failed to ensure staff completed the required amount of dementia care training in the required time frame for two of two employees (unlicensed personnel (ULP)-D, ULP-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee had an Assisted Living with Dementia Care license dated August 1, 2022. ULP-D ULP-D was hired February 1, 2022, to provide direct care services. On September 27, 2022, at 1:20 p.m. ULP-D was observed to administer oral medications to R2. ULP-D's employee record did not indicate a total of eight hours of the required dementia training was completed within 80 hours of the employee's start date. ULP-D's employee record indicated the	01540		

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01540	Continued From page 54 employee had completed 0.25 hours of dementia training. ULP-E ULP-E was hired on April 21, 2022, to provide assisted living services. On September 26, 2022, at 3:00 p.m. ULP-E was observed to verbally interact with R3 alone in her room. ULP-E's employee record did not indicate a total of eight hours of the required dementia training was completed within 80 hours of the employee's start date. ULP-E's employee record indicated the employee had not completed any dementia training. On September 29, 2022, at 2:30 p.m. registered nurse (RN)-I verified ULP-D and ULP-E lacked the required eight hours of dementia training with 80 working hours. The licensee's 3.01 Assisted Living with Dementia Care Additional Dementia Staff Training policy noted staff who work with residents with Alzheimer's disease and other dementia have proper training for the tasks assigned. The policy lacked the required dementia training hours. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 55 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a change in condition assessment for one of one resident (R3). In addition, the RN failed to complete a 14-day assessment timely for one of one resident (R1). 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 an isolated scope (when one or a limited number of residents are affected or one or	01620		

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01620	Continued From page 56 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 Change of Condition R3's diagnoses included Parkinson's disease (a disease of the nervous system that affects movement, often including tremors), Lewy Body dementia (a type of dementia that affects the brains' ability to effectively problem solve and reason), hallucinations and history of lower extremity blood clots. During observation on September 28, 2022, at 8:30 a.m. unlicensed personnel (ULP)-D cleansed a wound on R3's upper LEFT buttock area with soap and water followed by pat drying. ULP-D stated that they provided wound care twice daily that included zinc oxide daily and hydrocortisone twice daily to the wound area. Staff were to encourage R3 use the "donut pillow" two of which were found in R3's room, one on her recliner and the other on another wooden chair. ULP-D stated she had some confusion with the wound care order in the electronic medication administration record (eMAR) and would ask the nurse for clarification. ULP-D failed to cover the open wound following cleansing. R3's medication administration (MAR) dated September 2022, included - "zinc oxide to RIGHT buttock, topically one time a day for pressure sore. Clean with warm soapy water, rinse, tap dry, apply thick layer of ointment, cover with gauze and tape or foam dressing if available. Change daily" (Prescriber orders and start date of January 21, 2022).	01620		

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01620	Continued From page 57 R3's MN Comprehensive2 assessment dated April 27, 2022, when registered nurse (RN)-B indicated in section 4. Skin condition "skin currently closed, continue to monitor for re-occurrence." R3's document labeled "MN Medication/Treatment/Therapy Assessment and Plan2" dated April 27, 2022, indicated R3 was not receiving wound care treatment at that time. R3's MAR dated September 2022, further indicated hydrocortisone to wound twice daily (starting on May 11, 2022) and included the direction to "apply to buttock topically (to the skin) two times a day for sore on buttock, until healed." The licensee failed to complete an RN assessment and wound measurement when it appeared R3's wound had recurred. On June 15, 2022, R3's provider wrote specific wound care instructions that included duoderm to buttock wound, change every three days or if soiled. Need to offload the area as much as possible. Prescriber orders also included hydrocortisone cream one (1)%- applied to affected area twice daily until healed and zinc oxide to affected area daily. The licensee failed to complete an RN assessment for a change in condition regarding evidence of a wound, and lacked wound measurements. R3's MN 90 Day Review2 assessment dated July 25, 2022, in section 2. Recap of health status since last review. "She [R3] has a coccyx open area that is being treated with zinc oxide twice daily. Was using hydrocortisone cream previously without any healing noted." The licensee's MN 90 Day Review2 assessment appeared lacked the required assessment content. Additionally, the	01620		

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01620	Continued From page 58	01620		

assessment lacked a thorough RN assessment of R3's wound to include measurements and wound appearance.

On August 15, 2022, R3 had a wound clinic appointment. On August 16, 2022, a new order for amoxicillin 875 milligrams (mg) twice daily for seven days for wound treatment arrived at the licensee's nurse's office. The licensee failed to follow up with the wound clinic for documentation or notes regarding this visit and the new medication, and failed to complete a RN assessment of the wound including wound condition and measurements.

On September 28, 2022, at approximately 9:10 a.m. licensed practical nurse (LPN)-C stated she had looked at R3's wound many times and also measured it when R3 returned from the wound clinic on August 15, 2022; however, she did not document the encounter or the measurements.

On September 28, 2022, at approximately 9:30 a.m. the surveyor inquired about R3's wound clinic visit notes from August 15, 2022. LPN-C was unable to find a note and called the wound clinic to ask for documentation.

On September 28, 2022, at approximately 12:00 p.m. the wound clinic faxed a visit note that indicated a change in treatment for R3's buttock wound to include "cleanse wound with normal saline or soap and water and apply medihoney gel as sent with patient to wound base. Cover with mepi-dressing bordered foam or an equal foam dressing." The document did not include wound measurements, but indicated a "stage 3 wound" (where the wound has progressed through the second layer of tissue into the muscle). LPN-C was in contact with the wound

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01620	Continued From page 59 clinic to clarify orders regarding zinc oxide and hydrocortisone and to alert them the wound care order written by the wound clinic was just discovered. On September 29, 2022, at approximately 2:40 p.m. the surveyor observed LPN-C measure R3's left buttock wound. Measurement indicated the wound was 1.0 centimeter (cm) wide and 1.8 cm long and had some granulated tissue (indication that the wound had started healing/closing) on the outer aspect of the wound. Additionally, a scant amount of blood was present on R3's incontinence pull up brief. On September 29, 2022, at approximately 2:40 p.m. registered nurse (RN)-I stated her expectation was the nurses measured and documented wound measurements on a weekly basis, and verified R3's record lacked a complete RN assessment since the wound developed and with known changes since May 2022. RN-I stated that the corporate team were looking at the licensee's 90-day RN assessment tool and verified it lacked the required comprehensive content. R1 14 Day Assessment R1's record lacked evidence the RN conducted a reassessment no more than 14 calendar days after initiation of services. R1's unsigned and untitled document identified as the service plan per facility staff last reviewed September 26, 2022, indicated R1 received services that included bathing assistance three times weekly, medication administration, and blood glucose checks as prescribed. R1's last three assessments were requested. A	01620		

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01620	Continued From page 60 form titled MN Comprehensive2 and identified as an admission assessment dated April 19, 2022, a form titled MN 14 day and identified as the 14-day assessment dated May 6, 2022, and a form titled MN 90 Day Review2 dated July 15, 2022, were provided. The May 6, 2022, assessment was 17 days from the last date of the assessment, exceeding 14 calendar days. On September 29, 2022, at 3:30 p.m. RN-I verified the assessment was greater than 14 days from the initiation of services and was not sure how the facility RN was tracking the dates. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2022, indicated 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The	01640		

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01640	Continued From page 61 service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included Parkinson's disease with Lewy body dementia, anxiety, depression and visual hallucinations. R3's Service Plan integrated into facility electronic	01640		

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01640	Continued From page 62	01640		

care plan dated October 14, 2021, indicated R3 received services which included medication administration and dressing and grooming cues. The service/care plan appeared to have an updated "focus/goal/interventions/tasks" initiated on April 29, 2022, indicating R3 received bathing/showering assistance once a week and PRN [as needed]. It also indicated "R3 prefers assistance to wash and dry back and hard to reach areas." The service plan lacked the service of the wound care treatment that was provided.

R3's Task record dated September 2022, included a designated area for staff to document "as needed" showers; however the task record lacked any staff initials to indicate any additional showers were provided by the facility.

On September 28, 2022, at approximately 8:00 a.m. unlicensed personnel (ULP)-D was observed to administer medications and completed wound care with R3. ULP-D stated that the staff do not do routine showers, but R3's daughter did this on a weekly basis.

On September 26, 2022, at approximately 3:00 p.m. R3's resident representative/daughter stated she came weekly to complete R3's shower. R3's daughter stated she was not certain how staff were managing R3's wound care.

On September 29, 2022, at approximately 11:00 a.m. licensed practical nurse (LPN)-C indicated she didn't think R3 received showers by staff. LPN-C reviewed the memory care roster for bathing and confirmed R3 was not listed.

On September 29, 2022, at approximately 2:00 p.m. RN-I stated R3's service plan should reflect

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01640	Continued From page 63 the current services being provided and confirmed the service plan had not been revised regarding wound care and showering. The licensee's Contents of Service Plans policy dated August 1, 2022, indicated service plans would be revised as needed based on resident reassessments and monitoring. The policy also indicated that the licensee would implement and provide all services indicated in the service plan. 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	01650		

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01650	Continued From page 64 identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all the required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1's unsigned and untitled document identified as the service plan per facility staff, last reviewed September 26, 2022, indicated R1 received services that included bathing assistance three times weekly, medication administration, and blood glucose checks as prescribed. The document included a description of the services to be provided, the frequency of each service, and the identification of staff who would provide the services.	01650		

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01650	Continued From page 65 On September 27, 2022, at 10:33 a.m. unlicensed personnel (ULP)-D was observed to check R1's blood sugar and administer oral medications. R1's Service Plan lacked the following: - the fees for services; - 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: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2 R2's unsigned and untitled document identified as the service plan per facility staff, last reviewed November 22, 2021, indicated R2 received services that included medication administration and medication set up by nurse each week. The document included a description of the services to be provided, the frequency of each service, and the identification of staff who would provide the services.	01650		

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01650	Continued From page 66 On September 27, 2022, at 1:30 p.m. ULP-D was observed to administer oral medications to R2. R2's Service Plan lacked the following: - the fees for services; - 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: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3 R3's Service Plan integrated into facility electronic care plan dated October 14, 2021, indicated R3 received services which included medication administration and dressing and grooming cues. The service/care plan appeared to have an updated "focus/goal/interventions/tasks" initiated on April 29, 2022, indicating R3 received bathing/showering assistance once a week and PRN [as needed]. The licensee also provided wound care to R3 twice daily.	01650		

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01650	Continued From page 67 On September 28, 2022, at approximately 8:00 a.m. ULP-D was observed to administer medications and completed wound care with R3. R3's Service plan lacked the following required components: (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 and; (4) the schedule and methods of monitoring staff providing services. On September 28, 2022, at 10:40 a.m. licensed assisted living director (LALD)-A verified the untitled document the licensee was using for a service plan did not include the required components. LALD-A stated the same format would be utilized for all residents. On September 29, 2022, at 1:56 p.m. registered nurse (RN)-I stated when [The Licensee] had taken over ownership earlier this year, all new service plans should have been completed with the residents, but this had not been done. The licensee's 6.08 Service Plan policy dated August 1, 2021, noted the service plan would include: - fees for services to be provided; - schedule and methods for the next planned assessment or monitoring; - schedule and methods for the next planned	01650		

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01650	Continued From page 68 monitoring of staff providing services; and - a contingency plan that includes: i. Actions [The Licensee] will take if scheduled services cannot be provided; ii. Information regarding how the resident can contact [The Licensee]; iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the residents condition; iv. identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; v. How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 a reassessment when there was a known drug interaction in the	01710		

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resident's medications for one of three residents (R3) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R3 diagnoses included Parkinson's disease (a disease of the nervous system that affects movement, often including tremors), Lewy Body dementia (a type of dementia that affects the brains' ability to effectively problem solve and reason), hallucinations and history of lower extremity blood clots.

R3's service plan addendum D dated July 13, 2021, indicated the licensee provided medication management.

On September 28, 2022, at 8:00 a.m. unlicensed personnel (ULP)-D was observed to give R3 medications.

R3's medications included one medication to manage Parkinson's disease (related movement and tremors), two supplements, one for blood thinner, one for dementia, two for depression, two for blood pressure, one for sleep, two for wound care, one for cholesterol, one for skin rash, and one for mild pain.

An untitled document referred to as "the care

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plan/service plan", with a "medications" section dated April 29, 2022, read "communicating with the prescriber(s) and the pharmacy would be done by the community staff and that the community handles and implements changes to the prescriptions."

On August 16, 2022, R3 was prescribed amoxicillin 875 milligrams (mg) twice daily for seven days for wound healing.

On August 16, 2022, R3's document named [licensee name] Progress Notes indicated an "automated entry" with possible medication interactions between a newly prescribed amoxicillin (an antibiotic to treat infection) and Coumadin (medication used to thin blood). The interaction information indicated the severity as "moderate". The interaction comment included, "The direction and extent of the effects on clotting vary." The licensee failed to ensure that the RN followed up with R3's provider with documentation of discussion or that a medication reassessment was completed.

The licensee failed to complete a medication reassessment when a known possible medication interaction occurred.

On September 29, 2022, at approximately 2:30 p.m. RN-I stated their electronic medical record system has a built-in feature that sent alerts for drug interactions. RN-I stated her expectation was that when a "triggered" notification for drug interactions was received, the nurse would follow up by notifying the resident's physician, follow directives given, document in the resident's record and complete a medication reassessment.

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01710	Continued From page 71 The licensee's Medication policy dated August 1, 2021, indicated "5. [The licensee] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at minimum, annually." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to specify in writing, specific instructions and documented those instructions for one of one resident (R3), for medication administration delegated to unlicensed personnel. 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	01750		

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resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R3's record lacked specific written instructions regarding the administration of Coumadin (a medication to thin blood).

R3's diagnoses included Parkinson's disease (a disease of the nervous system that affects movement, often including tremors), Lewy Body dementia (a type of dementia that affects the brains' ability to effectively problem solve and reason), hallucinations and history of lower extremity blood clots.

R3's Service Plan Agreement signed July 29, 2021, indicated R3 received assistance with bathing, grooming, and medication administration.

R3's medications included one medication to manage Parkinson's disease (related movement and tremors), two supplements, one blood thinner, one for dementia, two for depression, two for blood pressure, one for sleep, two for wound care, one for cholesterol, one for skin rash, and one for mild pain.

On September 28, 2022, at 8:00 a.m. unlicensed personnel (ULP)-D was observed to administer oral medications to R3.

R3's medication administration record (MAR) dated September 2022, included Coumadin with doses of two and a half milligrams (mg) and five

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01750	Continued From page 73 mg given on alternating days for deep vein thrombosis (DVT). The MAR included instructions for ULP that read "do not touch with bare hands, use gloves to pick up if dropped. HAZARDOUS MEDICATION." The licensee failed to include instructions regarding the need to monitor and report any concerns with R3 with bruising or bleeding. On September 29, 2022, at 2:00 p.m. registered nurse (RN)-I confirmed there were no specific instructions to monitor for bruising or bleeding on R3's MAR. RN-I made edits to R3's MAR to include this direction. Licensee's Medications and Treatment-Administration and Delegation (7.15) policy dated August 1, 2021, read "When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [the licensee] will ensure that the registered nurse has: 1. Instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures. 2. Specified, in writing, specific instructions for each resident and documented those instructions in the residents' record. 3. Communicated with the ULP about the individual needs of the resident." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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01770	Continued From page 74	01770		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R2). 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: During the entrance conference on September 26, 2022, at approximately 11:15 a.m., registered nurse (RN)-B confirmed the licensee provided medication management services to the licensee's residents, including medication setup. R2's unsigned and untitled document identified as the service plan per facility staff last reviewed November 22, 2021, indicated R2 received services including medication administration and medication set up by nurse each week.	01770		

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01770	Continued From page 75 R2's MN Medication/Treatment/Therapy Assessment & Plan2 dated June 3, 2022, identified R2 needed combined administration and set-up of medications. R2's prescriber orders dated June 21, 2022, included the following orders: Acetaminophen extra strength (pain reliever) two tablets by mouth three times a day; amlodipine besylate (for blood pressure) 10 milligrams (mg) one tablet by mouth one time a day; atorvastatin calcium (for cholesterol) 80 mg 0.5 tablet by mouth one time a day; sennosides (for constipation) two tablets daily; glucosamine-chondroitin (supplement) two capsules by mouth one time a day; Icaps (supplement for eye health) one capsule by mouth two times a day; metoprolol tartrate (for blood pressure) 50 mg 1.5 tablets by mouth two times a day; multivitamin (supplement) one tablet by mouth one time a day; omeprazole (gastric acid reducer) 20 mg by mouth two times a day; triamterene (for fluid management) 75/50 mg 0.5 tablet by mouth one time a day. On September 27, 2022, at 1:20 p.m., unlicensed personnel (ULP)-D was observed to administer oral medications to R2. The scheduled medication was in a preset-up mediminder (medication dispenser) box. R2's record included a paper medication administration record (MAR) dated for September 2022, that indicated the licensed practical nurse (LPN)-C had set-up medications for R2 from September 7, 2022, to September 12, 2022. The MAR lacked documentation by a licensed nurse beginning September 13, 2022, to include the name of medication, quantity of dose, times to be administered, and route of administration.	01770		

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01770	Continued From page 76 On September 27, 2022, at 2:35 p.m. LPN-C stated she had completed the weekly medication set-up for R2 but did not document the medication set-up had been completed, or what medications, quantity of dose, times, or route. At this time, RN-B verified the expectation for medication set-ups was to initial the medications at the time of set-up for the number of days completed. The licensee's 7.08 Medication Management - Administration & Setup policy dated August 1, 2021, noted a licensed nurse would correctly and accurately document any medication setup provided. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were securely stored in the nurse's office mini-refrigerator. This had the potential to affect seven of seven residents (R1, R4, R8, R9, R10, R11, R12) who had medications stored in the refrigerator. This practice resulted in a level two violation (a	01880		

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01880	Continued From page 77 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 September 26, 2022, at approximately 11:30 a.m. during the entrance conference, registered nurse (RN)-B verified the licensee provided services including medication management and storage. On September 28, 2022, at approximately 9:10 a.m. the surveyor observed a mini-refrigerator located in the nurse's office on the second floor of the facility. The refrigerator did not have a lock and the nurse's office door (an accordion style door) also did not lock. The contents of the refrigerator included: R1- Lantus solostar (long acting insulin) -two cartridges R4- lorazepam (anxiety)- 30 milliliters (ml) R8- novolin (short acting insulin)-seven cartridges R9- Bydureon (weekly medicine to help control blood sugar levels)-one syringe R9- Lantus solostar (long acting insulin)- two cartridges R10- latanoprost eye drops (for glaucoma-high pressures in the eyes)-2.5 ml R10- dorzolamide eye drops (for glaucoma)-10 ml R11- latanoprost eye drops (for glaucoma)-2.5 ml R12- sulfcet sodium eye drops (antibiotic for the	01880		

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01880	Continued From page 78 eyes)-15 ml facility- tubersol (for testing staff for tuberculosis)-three half ml bottles On September 28, 2022, at 9:10 a.m. licensed practical nurse (LPN)-C stated she had been asking for a way to lock the nurse's office door for quite some time and has not gotten a response. LPN-C verified the contents of the refrigerator and the need to securely store the medications. The licensee's medication storage policy dated August 1, 2021, read medications managed outside of a resident's private living space must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained including the opened date for	01890		

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01890	Continued From page 79 time sensitive medication storage for the facility's tuberculin solution. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 28, 2022, at approximately 9:10 a.m. the surveyor observed a mini-refrigerator in the nurse's office located on the second floor of the facility. The contents of the refrigerator included a vial of Tubersol solution (an injectable solution to test for tuberculosis). The solution was in a multi-use vial and was missing the cap which indicated it had been opened and accessed. The vial lacked an "opened date" as required for safe storage. The manufacturer's storage instructions dated November 9, 2020, indicated "A vial of Tubersol which has been entered and in use for 30 days should be discarded." On September 28, 2022, at 9:10 a.m. licensed practical nurse (LPN)-C verified the vial lacked an opened date and had been used. LPN-C could not determine when the vial was first "entered" and would not be able to determine if it had been longer than 30 days. LPN-C indicated she was familiar with the storage requirements and discarded the vial.	01890		

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01890	Continued From page 80 The licensee's medication storage policy dated August 1, 2021, indicated medication would be stored consistent with manufacturer's recommendations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the	01910		

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01910	Continued From page 81 medication including the medication's name, strength, prescription number, quantity, to whom the medications were given, date of disposition, and the names of staff and other individuals involved in the disposition, for one of one discharged resident (R4) with record review. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4's records indicated R4 had a start of services date of October 5, 2015, and was discharged to a nursing home on August 8, 2022. R4's record indicated R4 received services including medication administration. R4's medication administration record (MAR) dated August 2022, indicated R4 received acetaminophen (for mild pain), lorazepam liquid and tablet form (for anxiety, restlessness and shortness of breath), Morphine sulfate (for pain and shortness of breath), nitroglycerin (for chest pain), and senna-plus (for constipation). On September 27, 2022, at 3:15 p.m. registered nurse (RN)-B verified R4's medications at time of discharge, were not documented and stated "I'm not sure what medications were sent. I'm assuming it was what the most recent MAR showed. She [R4] was on hospice earlier and was taken off most of her medications." RN-B also indicated that she was going to develop a	01910		

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01910	Continued From page 82 resident discharge checklist that would be followed to ensure the proper procedures were followed regarding discharges and medications at time of discharges. The licensee's 7.23 Medications Disposal policy dated August 1, 2021, included: Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

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01940	Continued From page 83 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to include in the service plan a written statement of the treatment or therapy services that will be provided to one of three residents (R3) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3's diagnoses included Parkinson's disease (a disease of the nervous system that affects movement, often including tremors), Lewy Body dementia (a type of dementia that affects the	01940		

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01940	Continued From page 84 brain's ability to effectively problem solve and reason), hallucinations and history of lower extremity blood clots. R3's service plan dated July 29, 2021, indicated R3 received services including medication management, weekly showers, and grooming assistance. On September 28, 2022, at 8:30 a.m. unlicensed personnel (ULP)-D was observed to cleanse a wound on R3's upper LEFT buttock area with soap and water followed by pat drying. ULP-D stated they provided wound care twice daily which included zinc oxide daily and hydrocortisone twice daily to the wound area. Staff were to encourage R3 to use the "donut pillow" two of which were found in R3's room; one on her recliner and the other on a wooden chair. ULP-D stated she had some confusion with the wound care order in the electronic medication administration record (eMAR) and would ask the nurse for clarification. R3's document labeled "MN Medication/Treatment/Therapy Assessment and Plan2" dated April 27, 2022, indicated R3 was not receiving wound care treatment at that time. R3's medication administration record (MAR) dated September 2022, indicated hydrocortisone to wound twice daily (started on May 11, 2022), and included the direction to "apply to buttock topically (to the skin) two times a day for sore on buttock, until healed." On June 15, 2022, R3's provider wrote specific wound care instructions that included duoderm to buttock wound, change every three days or if soiled. Need to offload the area as much as possible. Wound care orders included:	01940		

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01940	Continued From page 85 hydrocortisone cream 1 %- applied to affected area twice daily until healed; and zinc oxide to affected area daily. R3's MN 90 Day Review2 assessment dated July 25, 2022, in section 2. Recap of health status since last review. "She [R3] has a coccyx open area that is being treated with zinc oxide twice daily. Was using hydrocortisone cream previously without any healing noted." On September 28, 2022, at approximately 9:15 a.m. licensed practical nurse (LPN)-C stated "If the ULP have questions about a treatment or medications, they know to call the nurse. I've made some edits to R3's MAR for the times that the ointments are to be applied. They know to open the 'additional information' section in the eMAR to see more information about the wound care and covering the wound, and if they don't have supplies, they are to call the nurse. I have additional wound care supplies in the nurse's office." R3's record lacked a treatment plan to include the following: - a statement of the type of services that will be provided (it was not included in the service plan) - 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,	01940		

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01940	Continued From page 86 verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On September 29, 2022, at approximately 2:30 p.m. RN-I verified the licensee failed to develop a treatment plan at the time the wound developed and any time after wound changes occurred or with changes in treatment orders. Additionally, RN-I verified that R3's record lacked wound monitoring direction for ULP. The licensee's Medication and Treatment policy 7.05 dated August 1, 2021, indicated that for each resident at Cornerstone Management Services receiving management of ordered or prescribed treatments or therapy services, the facility would prepare and include in the service plan a written statement of the treatment or therapy services that would be provided to the resident and would include 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 (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	01940		

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01940	Continued From page 87 treatment or therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not administered, for one of three residents (R3). 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	01960		

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01960	Continued From page 88 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included Parkinson's disease (a disease of the nervous system that affects movement, often including tremors), Lewy Body dementia (a type of dementia that affects the brain's ability to effectively problem solve and reason), hallucinations and history of lower extremity blood clots. R3's record indicated R3 had been receiving wound care treatment to a LEFT buttock wound since May 2022. R3's medication administration record (MAR) dated September 2022, indicated R3 received zinc oxide to RIGHT buttock wound daily (indicated an order dated January 21, 2022) and hydrocortisone cream to LEFT buttock wound twice daily. Additional instructions indicated "cleanse with soap and water, pat dry, cover the wound with a thick layer of zinc oxide ointment and cover with gauze and tape or foam dressing, if available." On September 28, 2022, at approximately 8:30 a.m. unlicensed personnel (ULP)-D was observed to cleanse R3's LEFT buttock wound with soap and water and pat dry. The wound was left uncovered. ULP-D stated she needed to clarify with the nurse, the treatment of zinc oxide or hydrocortisone as the electronic medication record (eMar) had some changes and were confusing. On September 28, 2022, at approximately 9:15	01960		

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01960	Continued From page 89 a.m. licensed practical nurse (LPN)-C stated when the ULP had questions or concerns they were to notify nursing, and have not done so. LPN-C stated she had just made some time changes regarding hydrocortisone and zinc oxide. LPN-C stated the staff know to open an expanded area to see further directions/instructions regarding medications or wound care. LPN-C further stated the ULP know to call nursing if there was a need for more dressing supplies, as the supplies are stored in the nurse's office. On September 28, 2022, at approximately 4:30 p.m. LPN-C verified that the wound was on the LEFT buttock, and did not know why the zinc oxide MAR entry indicated RIGHT buttock. On September 29, 2022, at approximately 2:40 p.m. the surveyor observed LPN-C measure R3's left buttock wound. The wound was observed uncovered before measurement and LPN-C also failed to cover with a dressing following her measurement. When the surveyor indicated that the wound continued to lack a dressing, LPN-C stated she would need to "find out what was up with the dressing supplies and why the wound was not covered from the wound treatment provided the night before." The surveyor and LPN-C reviewed R3's September 2022, MAR and identified ULP-J had documented completing wound care on September 28, 2022, at 8:00 p.m. On September 29, 2022, at approximately 3:15 p.m. the surveyor and LPN-C met with ULP-J and asked ULP-J about her understanding of the wound care treatment and need to cover the wound. ULP-J stated staff documented on the tablet and followed what was written in the eMAR. LPN-C showed ULP-J where to expand the	01960		

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01960	Continued From page 90 directions that indicated the wound dressing order/instruction. ULP-J stated she had not been opening that expanded direction area and did not know the wound was to be covered. The licensee's Medication and Treatment Orders 7.20 policy dated August 1, 2021, indicated that the licensed nurse would monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. And a resident's MAR would be audited regularly by a licensed nurse or designee for documentation compliance. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure up to date written or electronically recorded orders were maintained for one of three residents (R3) receiving treatments.	01970		

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01970	Continued From page 91	01970		

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R3's diagnoses included Parkinson's disease (a disease of the nervous system that affects movement, often including tremors), Lewy Body dementia (a type of dementia that affects the brains' ability to effectively problem solve and reason), hallucinations and history of lower extremity blood clots.

R3's record indicated R3 had been receiving wound care treatment to a LEFT buttock wound since May 2022.

R3's medication administration record (MAR) dated September 2022, indicated R3 received zinc oxide to RIGHT buttock wound daily (indicated an order dated January, 21, 2022) and hydrocortisone cream to left buttock wound twice daily. Additional instructions indicated "cleanse with soap and water, pat dry, cover the wound with a thick layer of zinc oxide ointment and cover with gauze and tape or foam dressing, if available.

On September 28, 2022, at approximately 8:30 a.m. unlicensed personnel (ULP)-D was observed to cleanse R3's left buttock wound with soap and water and pat dried. The wound was left uncovered. ULP-D stated she needed to clarify

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01970	Continued From page 92	01970		

with the nurse, the treatment of zinc oxide or hydrocortisone as the electronic medication record (eMar) had some changes and were confusing. ULP-D stated that R3 "had concerns with wounds on and off over the past year or so."

On August 15, 2022, R3's daughter took R3 to the wound clinic for further evaluation of her left buttock wound.

On August 16, 2022, the licensee's nurse's office received a filled prescription for amoxicillin (antibiotic) 875 milligrams (mg), one tablet twice daily for seven days, for wound healing.

On September 28, 2022, at approximately 9:10 a.m. licensed practical nurse (LPN)-C stated stated the amoxicillin "showed up on her desk on August 16, 2022," and LPN-C entered the antibiotic information into the eMAR and initiated the medication. LPN-C stated the order came from R3's primary physician. LPN-C stated that she did not call R3's primary physician or the wound clinic for follow up information from the August 15, 2022, wound appointment. LPN-C stated "we don't have a good process for when families manage doctor's appointments, sometimes I don't know about them. She [R3] goes a lot for lab draws for her Coumadin (blood thinning medication) and the ULP don't always let us know that R3 is gone or that she had returned. Families are supposed to call and let us know if there is an appointment that they arrange, but sometimes this doesn't happen."

On September 28, 2022, at approximately 10:00 a.m. the surveyor requested the wound clinic documentation from the August 15, 2022, appointment. LPN-C stated that she had not received anything. LPN-C agreed to call the

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01970	Continued From page 93 wound clinic and request documentation of that appointment. On September 28, 2022, at approximately 12:00 p.m. LPN-C received documentation from the wound clinic dated August 15, 2022, that indicated a new treatment order for R3's wound. The order read "cleanse with normal saline or soap/water, medihoney gel (sent with patient) to wound base, cover with mepilex bordered dressing or other foam dressing." The document did not include wound measurements but indicated a "stage 3 wound" (where the wound has progressed through the second layer of tissue into the muscle). LPN-C stated she was going to follow up with the wound clinic to alert them that the licensee was not aware of this new order, so order had not been initiated, and needed further direction/orders to discontinue the hydrocortisone and zinc oxide. On September 29, 2022, at approximately 2:00 p.m. registered nurse (RN)-I stated her expectation was the licensee's nurses would follow up with a family member who managed an appointment to ensure no new orders or instructions were provided. The licensee's 7.20 Medication & Treatment Orders policy dated August 1, 2021, indicated that the RN was responsible for assuring that current authorized prescriber orders for medications or treatments administered by the staff are kept on file in the resident's records. The licensed nurse will review all medication ant treatment orders for progress, effectiveness, and necessity on a regular basis and with resident change of condition. No further information provided.	01970		

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01970	Continued From page 94 TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed have hazard vulnerability assessment and safety risk 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). Findings include:	02040		

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02040	Continued From page 95 On 09/30/2022 between 09:30 AM to 12:30 AM, survey staff observed that no documentation was presented to confirm that a hazard vulnerability assessment or safety risk assessment has been completed or is current (DM)-K and (LALD) A verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented;	02110		

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02110	Continued From page 96 (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for three of three residents (R1, R2, R3). 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 included: The licensee currently held an Assisted Living with Dementia Care license. R1, R2, and R3's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	09/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 97 time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On September 29, 2022, at 3:25 p.m. licensed assisted living director (LALD)-A verified there was no evidence of any residents receiving the policies. LALD-A stated he was aware of this requirement but was in his second week of employment and was not aware residents had not received the required policies. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	09/30/2022

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02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	09/30/2022

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02170	Continued From page 99 by: Based on interview and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions for three of three residents (R1, R2, R3) who received services under an assisted living with dementia care license, and failed to develop an individualized activity plan based on the evaluation. for three of three residents (R1, R2, R3). 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: The licensee held an assisted living with dementia care license, effective August 1, 2022. R1 R1's diagnoses included diabetes, anxiety disorder, chronic pain syndrome, and dependence on renal dialysis. R1's record contained a Getting to Know You form that identified where R1 grew up, past career, marital status, number of children and grandchildren, favorite color, favorite movie, religion, interesting fact, and something on their bucket list that they could still do today. R1's record lacked an evaluation of the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns;	02170		

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02170	Continued From page 100 - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R2 R2's diagnoses included unspecified dementia, anxiety disorder, and major depressive disorder. R2's record contained a Getting to Know You form that identified where R2 grew up, past career, marital status, number of children and grandchildren, favorite color, favorite movie, religion, interesting fact, and something on their bucket list that they could still do today. R2's record lacked an evaluation of the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R1 and R2's record lacked the development of an individualized activity plan. R3 R3 diagnoses included Parkinson's disease (a disease of the nervous system that affects movement, often including tremors), Lewy Body dementia (a type of dementia that affects the brains' ability to effectively problem solve and reason), hallucinations and history of lower extremity blood clots. . R3's record contained a Getting to Know You form that identified where R3 grew up, past	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	09/30/2022

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02170	Continued From page 101 career, marital status, number of children and grandchildren, favorite color, favorite movie, religion, interesting fact, and something on their bucket list that they could still do today. R3's record lacked an evaluation of the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R3's record lacked the development of an individualized activity plan. On September 27, 2022, at approximately 3:15 p.m. R3's daughter stated that R3 needed more stimulation. R3's daughter was not aware of an activity evaluation completed by the facility for R3. R3's daughter stated she'd like to see the facility offer more options such as puzzles, reading, word searches and arts/crafts. On September 29, 2022, at 11:40 a.m. life enrichment coordinator (LEC)-H verified the missing components as noted above. LEC-H indicated she was not aware of the requirement and had not completed for any of the licensee's residents. The licensee's 3.05 Life Enrichment Programs, Activities & Outdoor Space policy dated August 1, 2021, included each resident would be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation would address the following: -past and current interests; -current abilities and skills;	02170		

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02170	Continued From page 102 -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. An individualized activity plan would be developed for each resident based on their activity evaluation. The plan would reflect the resident's activity preferences and needs. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
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 three of three residents (R1, R3, R5) with bed rails. This resulted in an immediate order for correction on September 27, 2022, at approximately 3:45 p.m. 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	09/30/2022

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02310	Continued From page 103	02310		

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:

R1
On September 26, 2022, at 3:00 p.m., the surveyor observed a bed rail on the right upper side of R1's bed. The device was a single, metal, rectangular-shaped device, that slid between the mattress and the bed frame. The device secured to the bed with straps around the bottom mattress. R1 stated she used the assistive device to get in and out of bed.

R1's diagnoses included diabetes, end stage renal disease (loss of kidney function) and dialysis dependent.

R1's Service Plan reviewed September 26, 2022, indicated R1 received services which included medication management, blood glucose checks, and assistance with bathing.

R1's Bed Rail Assessment, dated September 23, 2022, indicated R1 requested the bedrails for positioning assistance and reassurance. The assessment further identified R1 had a fall history and weakness following dialysis sessions. The assessment indicated R1 was independent getting in and out of bed and was forgetful.

R1's record included a form titled Bed Rails Intended Purpose and Potential Risks. The form included intended purpose of bed rails and potential risks of bedrails. The form included R1's signature giving consent for the bed rail.

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02310	Continued From page 104 R1's record lacked manufacturer's instructions for the assistive device to ensure the device was assessed as being appropriately used and installed properly. R3 On September 26, 2022, at 3:00 p.m., the surveyor observed a bed rail on the left upper side of R3's bed. The device was a round, oblong, metal device with fabric covering the entire open area. The bed rail was attached to a wooden board which was between the mattress and box spring. R3's diagnoses included Parkinson's disease, Lewy body dementia (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function), and anxiety. R3's Service Plan reviewed October 14, 2021, indicated R3 received services which included medication management, dressing cues, meal reminders, and assistance with bathing. R3's Bed Rail Assessment, dated September 23, 2022, indicated R3's family requested the bedrail for positioning assistance. The assessment further identified R3 had predisposing disease of body movements and balance. The assessment indicated R3 was independent getting in and out of bed and had moderate cognitive impairment. R3's record included a form titled Bed Rails Intended Purpose and Potential Risks. The form included intended purpose of bed rails and potential risks of bedrails. The form included R3's daughter/power of attorney consent for the bed rail per telephone conversation on	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 105 September 23, 2022, at 10:15 a.m. R3's record lacked manufacturer's instructions for the assistive device to ensure the device was assessed as being appropriately used and installed properly. R5 On September 27, 2022, at 4:30 p.m., the surveyor observed a bed rail on the right upper side of R5's bed. The device was a round, oblong, metal device with a fabric covering the open area except for the top which allowed a hand grasp. The bed rail was attached with a metal bar to a wooden board which was between the mattress and box spring and secured to the bed with straps around the bottom mattress. R5's diagnoses included Parkinson's disease, history of falling, and dementia. R5's Service Plan reviewed January 29, 2022, indicated R5 received services which included medication management, meal reminders, assistance with dressing, grooming, and bathing. R5's Bed Rail Assessment, dated September 23, 2022, indicated R3's family requested the bedrail for positioning assistance, safety, and medical condition. The assessment further identified R5 had predisposing disease of weakness and body movements. The assessment indicated R5 required reminders and cues for getting in and out of bed and had moderate to severe cognitive decline. R5's record included a form titled Bed Rails Intended Purpose and Potential Risks. The form included intended purpose of bed rails and potential risks of bedrails. The form included	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	09/30/2022

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02310	Continued From page 106 R5's son/power of attorney consent for the bed rail per telephone conversation on April 12, 2022. R5's record lacked manufacturer's instructions for the assistive device to ensure the device was assessed as being appropriately used and installed properly. On September 27, 2022, at approximately 3:30 p.m., registered nurse (RN)-B and licensed practical nurse (LPN)-C stated the manufacturer for R1, R3, and R5's bed rails were unknown. RN-B and LPN-C verified without the manufacturer instructions they would not know if R1, R3, and R5 were of appropriate age/size/weight and would not know if the bed rail had been installed or was being maintained appropriately without them. RN-B and LPN-C further indicated they would not know if the bed rails had been recalled on the Consumer Product Safety Commission (CSPC) and stated there were no additional interventions in place to ensure the residents' safety. The licensee's 6.30 Assessing the Safety of Bed Rails policy, dated August 1, 2021, indicated the RN would assess and evaluate the client's needs are and determine if the client can appropriately utilize the side rail. The RN would determine whether the side rail is installed per manufacturer guidelines and provide education regarding side rail safety and risks. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On September 28, 2022, at 5:14 p.m. the immediacy of correction order 2310 was removed; however, non-compliance remains at a	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 107 scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) Days	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *09/27/22*
Time: 12:02:40
Report: 7920221204

Food and Beverage Establishment Inspection Report

Location:
Arbor Garden Place
535 Canyon Drive Nw
Eyota, MN55934
Olmsted County, 55

Establishment Info:
ID #: 0038228
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073280194
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Get some test strips for checking the quaternary ammonium compound sanitizing solution concentration in the spray bottles.

Comply By: 10/27/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

You need to have someone trained and state certified to operate this kitchen.

Comply By: 10/27/22

Surface and Equipment Sanitizers

Hot Water: = at 181 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

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

Food and Equipment Temperatures

Type: Full
Date: *09/27/22*
Time: 12:02:40
Report: 7920221204
Arbor Garden Place

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: Eggs, milk, meat
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Corn, beans, butter, fruit
Violation Issued: No

Process/Item: Hot Holding
Temperature: !80 Degrees Fahrenheit - Location: Pasta
Violation Issued: No

Process/Item: Hot Holding
Temperature: 165 Degrees Fahrenheit - Location: Chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 139 Degrees Fahrenheit - Location: Beans
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -7 Degrees Fahrenheit - Location: Vegetabl;es, cheese, bread
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -4 Degrees Fahrenheit - Location: Meat
Violation Issued: No

Process/Item: Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: Milk, butter, juice
Violation Issued: No

Process/Item: Top Freezer
Temperature: 0 Degrees Fahrenheit - Location: Muffins, bread, coffee
Violation Issued: No

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

I acknowledge receipt of the inspection report number 7920221204 of 09/27/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed:_____
Sam Boysen
Public Health Sanitarian
Rochester District Office
507-206-2719
samuel.boysen@state.mn.us