



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

March 24, 2025

Licensee
Covered Bridge LLC
231 Washington Street
Holdingford, MN 56340

RE: License Number 419647
Health Facility Identification Number (HFID) 28686
Project Number(s) SL28686013

Dear Licensee:

On February 19, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed February 19, 2025. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective February 19, 2025.

State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 25, 2024, initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on February 19, 2025, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

0480 - Minimum Requirements; Required Food Services - 144g.41 Subdivision 1 Subd. 1a (a-B) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on February 19, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

Covered Bridge LLC

March 24, 2025

Page 3

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, slightly slanted style.

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28686	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/19/2025
NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 231 WASHINGTON STREET HOLDINGFORD, MN 56340		
(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 *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#28686013-1 On February 19, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 25, 2024. At the time of the survey, there were eleven (11) residents receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 evaluators ' 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 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 18, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 3 to the FBEIR for any compliance dates.	{0 480}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

December 2, 2024

Licensee
Covered Bridge LLC
231 Washington Street
Holdingford, MN 56340

RE: Conditional License Number 415436
Health Facility Identification Number (HFID) 28686
Project Number(s) SL28686013

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 25, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **March 2, 2025**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$9,500.00. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

St - 0 - 0630 - 144g.42 Subd. 6 (b) - Compliance With Requirements For Reporting Ma - \$3,000.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services \$3,000.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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(s) 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

CONDITIONAL LICENSE ISSUED:

MDH will issue Covered Bridge LLC 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 survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Covered Bridge LLC is in substantial 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:** Covered Bridge LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Covered Bridge LLC must provide the Department:
 - i. A list of the names and birthdates of any individuals Covered Bridge LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents including:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Covered Bridge LLC will contract with an RN to provide consultation concerning all resident(s) to whom Covered Bridge LLC provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Covered Bridge LLC. 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 Covered Bridge LLC and MDH must review the RN’s credentials and approve the selection. Covered Bridge LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Covered Bridge LLC in an effort to help Covered Bridge LLC 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 substantial compliance and/or concerns about observations. Covered Bridge LLC 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 substantial 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

Covered Bridge LLC and the RN consultant about a change. Each report will be electronically submitted to Brandon Mueller, State Evaluation Team, Health Regulation Division, at Brandon.W.Mueller@state.mn.us. Brandon Mueller can be reached at 651-247-2064 (office) with questions about reports. The content of the reports will include information such as:

- i. Progress towards correction of 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 Covered Bridge LLC to correct the violations cited during the survey as well as to determine the overall practice of Covered Bridge LLC 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 survey:** At the time of the follow-up survey, 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:** Covered Bridge LLC 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 substantial compliance

for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Covered Bridge LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Covered Bridge LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Covered Bridge LLC's assisted living facility license, and Covered Bridge LLC will correct any outstanding violations identified during the survey. If Covered Bridge LLC is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact Brandon Mueller directly at: 651-247-2064.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

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0 000	Initial Comments 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: SL28686013 On October 21, 2024, 2024, through October 25, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 11 residents; all receiving services under the Assisted Living Facility license. On October 22, 2024, an immediate correction order was issued for correction order 2310 at a scope and level of level three, widespread (I). On October 23, 2024, an immediate correction order was issued for correction order 1290 at a scope and level of level three, widespread (I). On October 25, 2024, an immediate correction order was issued for correction order 0630 at a scope and level of level three, widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 evaluators ' 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 SUBDIVISION 1-3.		
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 (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, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (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	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 21,	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 2024, at 8:45 a.m., licensed assisted living director (LALD)-B stated she was 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 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 (opens in a new window), 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 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not	0 250			

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0 250	Continued From page 4 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 the 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. 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 (opens in a new window), and Minnesota Rules, chapter 4659 (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in	0 250			

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0 250	Continued From page 5 writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. - I attest to that the assisted living facility has provided services to at least one resident during the immediately proceeding license year as required by Minn. Stat. sect. 144G.17 (5) (opens in new window). Page 6 was electronically signed by the licensee on June 30, 2023. The licensee had an Assisted Living license, issued on February 1, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in sections 626.557, reporting or maltreatment of vulnerable adults; - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with	0 250			

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0 250	Continued From page 6 current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals. As a result of this survey, the following orders were issued under 0510, 0630, 0660, 1290, 1470, 1500, 1530, 1620, 1690, 1700, 1760, 1770, 1820, 1880, 1890, 1940, 1970, and 2320. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 450 SS=D	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide services in a person-centered manner for one of two residents (R2).	0 450			

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0 450	Continued From page 7 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: R2's diagnoses included peripheral vascular disease, alcohol dependence, generalized idiopathic epilepsy, and anemia. On October 23, 2024, at 9:40 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's scheduled morning medications. R2's Service Plan Agreement dated May 17, 2023, indicated R2 received services including dining reminders, nail care, and bed making. It also indicated services to include: - wellness checks, noting "Locate [R2] and check on him face-to-face to ensure he is alive and well... Community to check on resident and address any needs."; and - alcohol use: Monitor, noting "FYI if resident returns from the bar, appears intoxicated, slurs there [sic] room staff must monitor them hourly. Vital signs of respirations, pulse and oxygen should be obtained as well as noting if they are arousable [sic]. Indicate in communication note if resident appears intoxicated and time hourly monitoring is initiated. If the resident is not responsive, unable to communicate, agitated or combative and unable to be directed call 911. The community to provide a safe environment if the Resident chooses to consume alcohol. The	0 450			

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0 450	Continued From page 8 community cannot take responsibility if the resident chooses to consume alcoholic substances." R2's Service Delivery Record for October 2024 noted "Alcohol Use: Monitor" and a slot for each day of the month. Each date noted either "2" or "3", and a note at the bottom read "A Number indicates the number of times a service was delivered on that day." On October 23, 2024, at 12:05 p.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated when he comes back drunk and obviously intoxicated, staff monitor him to make sure he is not falling or throwing up on himself, and added several times they had to clean up vomit and pick R2 up off the floor. LALD-B stated staff had not been educated on the signs and symptoms of alcohol poisoning to monitor for. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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	0 480			

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0 480	Continued From page 9 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 21, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 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	0 485			

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0 485	Continued From page 10 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; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include R1's Lease Agreement dated September 27, 2022, noted on page 5 "Hyatt House will provide the Resident with the following accommodations, which are included in the basic daily fee. 3 meals/day plus snack served in the dining area." On October 24, 2024, at 9:20 a.m., licensed assisted living director (LALD)-B stated all meals are included in the contract and she was not aware the licensee could not require a resident to	0 485			

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0 485	Continued From page 11 include and pay for meals in their contract. LALD-B stated this was the same for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of one employee (unlicensed personnel/ULP-C) observed to provide medication administration. This had the potential to affect all residents, visitors and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 510			

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0 510	Continued From page 12 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 23, 2024, at 8:20 a.m., the surveyor observed ULP-C administer insulin to R6 in his bed. The surveyor observed ULP-C administer the insulin into R6's abdomen without first wiping the site with an alcohol wipe. Upon exiting R6's room, ULP-C stated she had not wiped R6's abdomen and was not sure if she was trained to do so or not. On October 25, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated it was her expectation the abdomen or any site be wiped with alcohol prior to administration of the insulin. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=I	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;	0 630			

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0 630	Continued From page 13 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 observation, interview, and record review, the licensee failed to complete a comprehensive assessment of a resident's risk of abusing other vulnerable adults with statements of the specific measures to minimize the risk of abuse for one of eleven residents (R4), and failed to complete a comprehensive assessment of a resident's susceptibility to abuse by another individual with statements of the specific measures to minimize the risk of abuse for one of eleven residents (R5). This had the potential to affect all residents, staff, and visitors. This resulted in an immediate correction order on October 25, 2024. 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 failed to take immediate action to develop and implement specific measures to reduce R4's risk of harm to other residents and his self for actions including misuse of a motorized scooter and making threats to other	0 630			

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0 630	Continued From page 14 residents and staff. R4 From October 21, through October 24, 2024, the surveyor observed R4 multiple times throughout the survey in the halls and dining room on his motorized scooter. R4's diagnoses included hypertension, partial traumatic amputation at knee level to the left leg, phantom limb syndrome with pain, personality and behavioral disorders, current alcohol and recreational drug use. R4's Service Plan Agreement dated April 24, 2023, indicated R4 received services including transportation assist, bathing setup, dining reminders, assistance with compression stockings, assistance with nail care, setup for grooming, daily blood pressure, bed making, housekeeping, laundry, medication administration, monitoring alcohol use, and behavior management ("The community to provide assistance to monitor reactive behaviors in a supportive environment. Monitor and chart behaviors with other residents. The community to provide assistance to monitor reactive behaviors in a supportive environment"). R4's Behavior Assessment Plan dated June 24, 2024, completed and signed by licensed assisted living director (LALD)-B noted the following issues: - resident continues to display aggressive and threatening behavior towards caregivers and housemates; - makes rude comments and physical threats of harm; - history of running his wheelchair into housemates, throwing dishes, kicking, and hitting;	0 630			

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0 630	Continued From page 15 - law enforcement has been involved multiple times and assault charges are pending; - incontinent of urine and refuses to change clothing; - urinates in bottles in his room and refuses staff to remove them; - refuses to allow staff to clean his room; - destroys property when upset, and has broken three doors, dishes; - will run scooter into walls; - attempts to obtain an inpatient psychological evaluation have been unsuccessful and resident refusing cat scan. Current order for Rule 20 evaluation. Limited results seen on psychotropic medication (Seroquel). Staff try to redirect and assist with very little results. Intervention/action includes: - administer medications as prescribed; - document all aggressive and threatening behavior, notify LALD/RN, case manager and police if needed; - remove resident from any situation where aggressive or threatening behavior is displayed; - encourage resident to attend Rule 20 evaluation and follow through with results; - continue attempts for inpatient evaluation, therapist visit, or cat scan; - encourage resident to allow staff to clean room so it remains sanitary; - staff to monitor shared bathroom to ensure it stays clean and safe; and - resident to use only plastic/paper dishes in the dining room to ensure he is not breaking glass around house mates. R4's Master Assessment Template dated July 29, 2024, noted a current alcohol and recreational drug use, R4 had an electric wheelchair, had short-term memory impairment, occasionally needed redirection for mild disorientation to	0 630			

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0 630	Continued From page 16 person, place, or time, had behaviors including physical and verbal, was resistive to care, and had socially inappropriate behavior which required redirection, yells and swears at others, and comes out unpreventable in the community with redirection needed. It noted a monthly evaluation of behavior management needs by the nurse. It noted R4 was a high fall risk and required fall risk safety checks. It noted R4 denied pain. However, it also noted R4 had phantom left knee pain, and "Pain may interfere with resident mood and demeanor at times. Does have pain controller prescribed when needed." It also noted past traumatic brain injury (TBI) which effects R4's mood and memory. It noted missing teeth, and R4 became agitated when dentures were discussed and noted R4 was incontinent of urine. R4's record included the following incidents: - February 14, 2024, at 4:50 p.m. - incident report (IR) of resident to staff altercation. R4 yelling at a peer in the dining room. R4 was asked to go to his room and started to kick staff and yell at staff while going to his room. No injuries noted. R4's provider not notified. RN not notified. LALD notified. The IR section "Incident Investigation" was left blank. The form was signed as completed by unlicensed staff, but not signed by LALD or clinical nurse supervisor (CNS); - February 16, 2024, at 8:52 a.m. - progress note (PN) R4 was screaming at a peer in the dining room and proceeded to move towards her in her wheelchair. Staff intervened and R4 screamed at and kicked staff; - February 16, 2024, at 9:29 a.m. - PN peer reported to staff R4 had placed items in front of his door. Staff approached R4 and asked if he had things in the hallway. R4 began yelling and in front of peer's door and said "I put it there so	0 630			

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0 630	Continued From page 17 that he would trip on it." Staff asked R4 to remove items, and he continued to yell "I'll throw it in the fucking hallway". Staff removed the broken toaster oven; - February 16, 2024, at 2:48 p.m., - PN LALD-B heard R4 screaming from the office (on opposite corners of the building). When approached, R4 stated he had tipped his wheelchair over. When asked to keep in mind other people lived here, R4 screamed "Good I hope they all fucking hear me."; - February 19, 2024, at 12:22 p.m., - PN noted a neighbor had been complaining to staff about R4's behavior, and staff reported R4 was yelling at and threatening a peer, telling peer he was going to "beat his ass" and told staff they better call the police before he does something and added "I hope I get assault charges." It also noted over the weekend there were many reports of R4 yelling and screaming, kicking things in his room, and telling staff to "go to hell." - February 19, 2024, at 12:25 p.m., - PN noted R4 got upset with a peer and yelled "get out of my way you little dwarf". R4 backed his wheelchair up and ran over the scale, got upset and picked it up and threw the scale, breaking it; - February 26, 2024, at 2:15 p.m. - PN noted overnight R4 continued to kick his fridge in his room for about an hour; - March 11, 2024, at 8:09 a.m. - PN noted R4 yelling and screaming and throwing things overnight. Staff asked him to stop, but it went on for three hours. R4 began to kick a peer's door and staff called 911. Police came out and told staff there was an active warrant and to have resident call non-emergency number after breakfast. R4 was arrested that morning and taken to jail; - March 13, 2024, at 8:19 a.m., - PN noted R4 was released from jail and returned to the facility.	0 630			

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0 630	Continued From page 18 There was a court order prohibiting contact with a peer (no longer resides at the facility). Plan to keep safe included separate mealtimes, when peer was in hallway, R4 must stay away, in common areas if peer came in, R4 must leave, and if R4 intentionally tried to make contact or refused to leave when peer was around, the police would be called; - April 4, 2024, at 10:41 a.m. - PN noted R4 had court appearance for 5th degree assault charge. While meeting with public defender, R4 started to yell and scream and asked the attorney if he killed the other resident because that is what he wanted to do. Attorney asked for Rule 20 evaluation; - April 5, 2024, at 10:48 a.m., - PN noted R4 went into the dining room, and a peer was in the dining room with company. R4 began screaming and swearing at the peer for asking if it was cold outside; - April 8, 2024, at 5:00 p.m. - PN noted R4 spilled soup on himself and got upset and yelled at staff; - April 14, 2024, at 5:30 p.m. - PN noted two peers started arguing in the dining room and R4 screamed and threatened a peer. R4 stated he was going to beat up the peer. An incident report was completed. No injuries noted. R4's provider not notified. RN not notified. LALD notified. The IR section "Incident Investigation" noted no staff was present to witness. An IR for R5 noted R4 pinched him during the altercation. The form was signed as completed by unlicensed staff and signed by LALD. Provider not notified. RN not notified. No new interventions; - April 24, 2024, at 11:47 a.m., - PN noted a dispute in the dining room between two peers about one of the peer's dogs. After the situation was resolved, R4 yelled "just kill the mother fucker"; - May 1, 2024, at 12:58 p.m. - PN noted a	0 630			

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0 630	Continued From page 19 manager from the gas station in town came to offer a used motorized scooter for R4 that people from town had chipped in to buy, which was going to have the seat repaired and be ready next week; - May 13, 2024, at 11:55 a.m. - PN noted R4 received the motorized scooter; - May 15, 2024, at 8:15 a.m. - IR noted a physical altercation when R4 ran into and rammed the side and back of R5's wheelchair with his motorized scooter. No apparent injuries. Staff asked resident to stop and go around peer, and R4 began yelling at staff. No injuries noted. R4's provider not notified. RN not notified. LALD not notified. The IR section "Incident Investigation" was left blank. The form was signed as completed by unlicensed staff, but not signed by LALD or RN. IR for peer also completed with no injury noted R5's provider not notified. RN not notified. LALD not notified. The IR section "Incident Investigation" was left blank. The form was signed as completed by unlicensed staff, but not signed by LALD or RN. On May 15, 2024, at 11:58 a.m., a report was filed by LALD-G with Minnesota Adult Abuse Reporting Center (MAARC); - May 15, 2024, at 11:41 a.m. - PN noted R4 started hitting his table in the dining room. R4 then started to swear at staff telling them to "shut the fuck up" and flipped his table over. LALD-B intervened and asked R4 to return to his room and R4 yelled "Fuck him."; - May 28, 2024, at 12:09 p.m. - PN noted several reports over the weekend of R4 ramming his motorized scooter into things such as walls and tables and threatening to run peers over; - May 28, 2024, at 12:38 p.m. - PN indicated when LALD-B talked with R4 about the misuse of his motorized scooter, R4 yelled he had not misused or threatened anyone with his scooter	0 630			

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0 630	Continued From page 20 but could see himself doing it. R4 was informed that if he hurt another resident, they would have to restrict the use of the scooter in the building. R4 yelled he was going to call his brother and have him take him out of here; - May 28, 2024, at 10:12 a.m. - late entry PN for May 23, 2024, noted R4 broke the table in his room and tried to throw it out the window; - May 30, 2024, at 10:13 a.m. - late entry PN for May 27, 2024, noted staff heard loud banging from R4's room. R4 stated he was banging against the wall with the scooter "because I hate that mother fucker and I hope I ruin his night." Resident threatened to fight peer; - May 31, 2024, at 11:24 a.m. - PN noted R4 was outside the facility yelling at a peer; - June 5, 2024, at 12:15 p.m. - IR noted aggressive behavior with R4 upset he could not scoop up potatoes with his spoon and smashed his plate against the table, shattering it and cutting his thumb on his right hand. R4's provider not notified. RN not notified. LALD not notified. The IR section "Incident Investigation" was left blank. The form was signed as completed by unlicensed staff, but not signed by LALD or RN; - June 5, 2024, at 12:34 p.m. - PN noted after incident in dining room, R4 returned to his room and tore the door off the hinges; - June 6, 2024, at 7:59 a.m. - PN late entry for June 1, 2024, at 6:00 p.m., R4 ran the power scooter into the walls in his room; - June 7, 2024, at 8:33 a.m. - PN noted R4 would be using plastic plates and silverware. When asked why he continued to break things, R4 stated he would continue to break anything he could and began screaming at staff; - June 11, 2024, at 11:39 a.m. - PN indicated R4 brought paperwork for upcoming court date and asked staff to make a new appointment; - June 13, 20204, at 8:59 a.m., late entry for June	0 630			

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0 630	Continued From page 21 11, 2024, - PN indicated R4 tried to take a package delivered by the front door not addressed to him; - June 14, 2024, at 9:59 a.m. - PN indicated a court hearing was held and the judge reschedule the Rule 20 for July 9, 2024, at 12:00 p.m. via teleconference; - June 24, 2024, at 3:45 p.m. - IR noted resident to resident altercation note R4 stated "I'm going to fucking kill him and there's nothing you can do." R4 ran into R5 when entering the dining room, yelled at R5, and continued to run into him. Emergency services called. No injuries noted. R4's provider not notified. RN not notified. LALD notified. The IR section "Incident Investigation" noted 911 was called and R4 was charged with 5th degree assault. The form was signed as completed by unlicensed staff and signed by LALD. R5's IR dated June 24, 2024, at 3:45 p.m., noted peer reported pain in both hands. R5's provider not notified. RN not notified. LALD notified. MAARC report filed June 25, 2024, at 10:33 a.m.; - June 25, 2024, at 7:41 a.m. - PN indicated R4 threw his meds at staff and screamed "I'm not taking these fucking meds". R4 attempted to run staff's hands over when they tried to pick up the medication off the floor; - June 25, 2024, at 8:08 a.m. - PN indicated R4 has been refusing his quetiapine (psychotropic medication) and metoprolol (to treat high blood pressure); - June 26, 2024, at 2:02 p.m. - PN indicated R4 was throwing bingo pieces and card on the floor when told it was time to clear the board; - July 9, 2024, at 10:57 a.m. - PN indicated R4 asked staff for a peer's cigarettes and was told he could not get peer's cigarettes. R4 then called staff a "lazy bitch"; - July 11, 2024, at 10:52 a.m. - PN indicated R4	0 630			

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0 630	Continued From page 22 had the Rule 20 evaluation via telecommunication. After about 30 minutes, R4 started yelling and slammed the computer shut; - July 15, 2024, at 1:33 p.m. - PN indicated R4 threw his medications on the floor; - July 15, 2024, at 1:35 p.m. - PN indicated R4 admitted to throwing a chair in the dining room; - July 25, 2025, at 11:57 a.m. - PN indicated the Ombudsman came to visit with R4. LALD spoke with Ombudsman about concerns and issues with resident; - July 26, 2024, at 1:13 p.m., late entry for July 23, 2024, - PN indicated R4 threatened to break his plate; - July 31, 2024, at 8:49 a.m., late entry for July 30, 2024, - PN indicated R4 refused his medications stating he would "Never take another fucking med again" and stated to staff "Think about how much im [sic] going to fuck you up."; - August 1, 2024, at 1:30 p.m., - IR noted R4 ran into R5 with his motorized scooter when R5 was going down the hallway in his wheelchair. R4 yelled "dumb fuck". Staff intervened and R4 went to his room. R5's right hand got caught between the two wheelchairs. R4's and R5's provider not notified. RN not notified. LALD completed the IR. The IR section "Incident Investigation" was left blank. The form was not signed by RN; - August 8, 2024, at 9:25 a.m., late entry for July 31, 2024, - PN indicated R4 started yelling and cursing at staff when asked if he wanted to take his medications; - August 20, 2024, at 12:43 p.m., - PN indicated R4 was eating food off a peer's plate in the dining room. When asked what he was doing, R4 stated "I'm eating her food. I'm not being an asshole I am being smart."; - August 22, 2024, at 8:22 a.m., late entry for August 7, 2024, - PN indicated R4 was yelling and swearing when he could not hold on to a	0 630			

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0 630	Continued From page 23 magazine. R4 denied pain; - August 22, 2024, at 8:25 a.m., - PN indicated R4 ripped the toilet paper holder off the wall; - August 22, 2024, at 8:25 a.m., late entry for August 16, 2024, - PN indicated R4 was yelling and swearing at peer when they were both in the door way at the same time; - August 22, 2024, at 8:26 a.m., late entry for August 18, 2024, - PN indicated R4 got stuck on a chair by the staff area and rammed into the doorway to the dining room several times trying to break the chair. When asked to stop, R4 yelled "Add it to my god damn bill, im [sic] sure it's close to \$1000 by now. And I was trying to break it."; - August 22, 2024, at 8:29 a.m., late entry for August 19, 2024, - PN indicated R4 was sitting in the middle of the doorway reading a magazine when a peer wanted to get through. R4 yelled "fuck you, I don't care if you need to pee, fuck you"; - August 22, 2024, at 8:32 a.m., - PN indicated R4 called staff a "stupid prick" when attempting to take R4's blood pressure; - August 25, 2024, at 7:00 p.m. - IR noted resident to staff altercation. Staff arrived to work and heard R4 yelling from outside the building with the front door wide open. When staff entered the building, R4 was noted by the staff area waving a plate around and stated he was going to hit staff as soon as they walked through. Staff arriving asked R4 to stop or they would have to call the police, and R4 attempted to run staff over and hit them with the plastic plate in his hands. Police were called. No injuries noted. R4's provider not notified. RN not notified. LALD notified. The IR section "Incident Investigation" noted the police and R4's brother were notified. The form was signed as completed by unlicensed staff, signed by LALD but not RN; - August 26, 2024, at 11:10 a.m., - IR noted R4	0 630			

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0 630	Continued From page 24 was on the motorized scooter in the hallway and R5 was in his way. R4 started screaming "get out of my fucking way" and rammed his motorized scooter into R5 numerous times and pushed R5 against the wall in his wheelchair. Staff intervened and R4 yelled "shut the fuck up". R4 then raised a water bottle to throw at staff. R4 then turned his motorized scooter around and attempted to run into another resident who just entered the hallway. Staff jumped in front of the other resident and told R4 they would take the motorized chair if he did not stop. R4 became upset and came at staff threatening to hit staff and run them over. After multiple prompts, R4 returned to his room. No injuries noted. R4's provider not notified. RN not notified. LALD notified. The IR section "Incident Investigation" noted a MAARC report was filed. The form was signed as completed by unlicensed staff, signed by LALD but not signed by RN. R5's IR noted no injury. R5's provider not notified. RN not notified. LALD notified. Comments section noted R5 had no injuries. MAARC report filed. MAARC report filed by LALD-B on August 26, 2024, at 2:14 p.m.; - September 5, 2024, at 10:42 a.m., late entry for September 4, 2024, - PN indicated R4 was shouting and banging things in his room; - September 12, 2024, at 9:12 a.m., late entry for September 9, 2024, - PN indicated R4 was yelling and swearing when trying to get something out of his fridge. It noted R4 declined help from staff; - September 13, 2024, at 12:54 p.m., late entry for September 11, 2024, - PN indicated a peer asked R4 to move so he could get through the doorway. R4 began yelling and banged his motorized scooter into the peer's scooter multiple times, resulting in peer's basket on the scooter to be broken; - September 20, 2024, at 12:30 p.m., - IR indicated R4 had a verbal altercation with a peer,	0 630			

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0 630	Continued From page 25 and R4 told the peer "I can't believe they let a piece of shit like you live here." No injuries noted. R4's provider not notified. RN not notified. LALD not notified. The IR section "Incident Investigation" was left blank. The form was signed as completed by unlicensed staff, but not signed by LALD or RN; - September 23, 2024, at 10:08 a.m., - PN indicated R4 asked staff for a new cable box. When staff informed R4 they did not have a spare and would have to contact the cable company, R4 stated "Should I just throw the fucking TV away then". Staff went to R4's room to check the cable box and found the TV was completely broken with hardly any picture visible but the box was fine; - September 23, 2024, at 12:02 p.m., - PN indicated R4 began yelling and threw his food on the floor; - September 23, 2024, at 12:27 p.m., - PN indicated a notice was received from Stearns County public defender of a telecommunication hearing on October 7, 2024, at 10:00 a.m.; - September 24, 2024, at 8:24 a.m., late entry for September 17, 2024, - PN indicated R4 was yelling and screaming in his room and it went on for 10 minutes. Staff offered help and R4 declined; - September 24, 2024, at 8:26 a.m., late entry for September 18, 2024, - PN indicated staff went to help resident with his TV and noted R4 had flipped his table over and threw his mail on the floor. Staff tried to help pick it up and resident yelled to "Leave it the hell alone."; - September 24, 2024, at 8:27 a.m., late entry for September 19, 2024, - PN indicated resident went out for a stroll around town and his motorized scooter died. It noted someone from town "brought resident back to the facility on a forklift."; - September 24, 2024, at 8:28 a.m., late entry for	0 630			

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0 630	Continued From page 26 September 20, 2024, - PN indicated R4 used his motorized scooter to run into another resident in a shared hallway; - September 24, 2024, at 8:30 a.m., late entry for September 23, 2024, - PN indicated R4 threw his food on the floor because he did not like the type of noodles used. Staff tried to talk with R4 about it, but he yelled and screamed; - September 24, 2024, at 8:36 a.m., - PN indicated R4 came to dining room and began screaming at a peer he was going to "kick his ass". Staff asked R4 to leave the dining room, and R4 screamed at staff. When R4 left the dining room, he ran over staff's foot with his motorized scooter. R4 continued to yell "I'm going to wait for that mother fucker, he is going to get his ass beat today." R4 kept coming back to see if peer was still in the dining room; - September 24, 2024, at 11:37 a.m., - PN indicated R4 had broken a table in his room the facility had provided for him to use; - October 7, 2024, at 10:01 a.m., - PN indicated R4 attended court via telecommunication, and court ordered the Rule 20 evaluation; - October 10, 2024, at 11:30 a.m., late entry for September 25, 2024, - PN indicated R4 was yelling in his room. When staff asked why he was yelling, R4 stated "because it's something to do."; and - October 10, 2024, at 11:31 a.m., late entry for September 29, 2024, - PN indicated R4 was screaming and cursing in his room. R4's Vulnerability, Safety and Risk Assessment with Abuse Prevention Plan dated July 29, 2024, noted vulnerabilities with interventions needed including: - vulnerable to abuse against them from others - can easily be taken advantage of by house mates, asking for gifts of money in the past;	0 630			

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0 630	Continued From page 27 - anxiety/depression/mental illness - has uncontrolled anger issues and has been known to throw items and threaten house mates and facility staff; - ability to ambulate safely with/without assistive devices or safe use of assistive devices - will not use DME (durable medical equipment) properly at times. Fails to lock breaks on wheelchair. Does not ask for assistance when needed. Staff to monitor for safety of and use of DME and notify registered nurse (RN) of any concerns; - pain - no current concerns at this time; - history of self-neglect and unlikely to report abuse from others - staff are mandated reporters and to notify RN of any concerns; - alcohol/substance abuse - history of meth abuse and having substance on self. Due to this room is searched intermittently by staff; - history of starting fires in facility related to smoking - staff to store lighters in staff area; - verbal abuse - R4 yells and swears at house mates and staff; - threatening behavior - will have angry outbursts including throwing things, threatening to kick or hit house mates; - physical violence or potential harm, such as hitting, kicking, pushing, biting or grabbing or injury from improper use of scooters - documented that R4 has violent outbursts with hitting/kicking, yelling/swearing at house mates or facility staff; and - history of criminal charges - no current concerns at this time. Summary noted "Client is vuneralble [sic] to abuse/neglect by others and also can be a danger to those around him. Facility staff is to monitor and report any concerns to RN." It noted the assessment was based on the resident's chart, staff information and case files. Planned interventions are located in the care plan	0 630			

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0 630	Continued From page 28 (identified by LALD-B as the service plan). However, R4's Abuse Prevention Plan did not identify R4's use of his scooter as a weapon. Additionally, it did not identify R4 was at risk of self-abuse due to not ensuring the scooter was fully charged and/or R4 was unable to monitor the status of the battery while on outings, and also did not include specific measures to be taken to minimize risk of abuse to others and to self. R4's untitled contract dated October 18, 2021, noted under Termination by the Community section "In addition, we may initiate an expedited termination of services to you in any of the following circumstances: (1) You have engaged in conduct that substantially interferes with your own health or safety; (2) Your assessed needs exceed the scope of services agreed upon in this Agreement or offered at the Community as disclosed on the Uniform Checklist Disclosure of Services; or (3) Extraordinary circumstances exist, causing us to be able to provide you with the services necessary to meet your needs, even though the services are disclosed on the Uniform Checklist as available through the Community." A letter dated December 12, 2022, titled to discuss the assisted living contract termination was proposed for December 16, 2022. Reason for termination noted as "engaged in conduct that substantially interferes with the rights, health or safety of other residents, and destruction of property." A letter dated December 27, 2022, titled termination of assisted living contract noted the termination date of January 27, 2023. It noted "Your Assisted Living Contract will be terminated	0 630			

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0 630	Continued From page 29 for putting other resident's safety at risk by being violent and hitting and kicking them. [Resident's name] has made several threats to other resident about harming them. [Resident's name] has also destroyed Hyatt House property. And has been starting fires." It noted the facility was willing to create a new contract with the following conditions: - must attend regular therapy sessions; - must stop all violent behavior; - must pay for all destroyed property; and -would not be allowed to have any lighters on his person. A notice of the contract termination was sent to the Office of Ombudsman for Long-Term Care (OOLTC) on December 27, 2022. On July 3, 2024, time not indicated, correspondence from LALD-B sent to R4's provider noted "We do feel resident is a danger to other residents, himself and staff. However, resident is scheduled for a court ordered Rule 20 eval [evaluation] via zoom [telecommunication] on Tuesday July 9, 2024." Progress notes were sent along with behaviors. Response from provider included "Noted. What became of that" He'd be great for coordinated care clinic in St. Cloud. Thoughts/updated?" Fax dated July 25, 2024. July 26, 2024, time not indicated, a response from LALD-B sent to R4's provider noted "Regarding the incident report in question, we did have the police out. They were unable to do anything with [resident's name] going at another resident, because there were no injuries and there was not video footage. But we had a staff member who stepped in between them, and the staff member was assaulted. The police were able to charge [resident's name] with 5th degree	0 630			

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0 630	Continued From page 30 assault and disorderly conduct due to the staff member's injuries. This is not by any means the first incident like this. We have had the police out here numerous times for incidents just like this. He does have another pending court case for 5th degree assault against a different resident as well. In this case the court ordered him to take a Rule 20 evaluation. He did do this evaluation on July 9 via zoom. It was very short lived because he became angry and slammed the computer shut. We have not yet received the results. [Resident's name] moved in with us 10/18/21 [October 18, 2021] and we have had similar issues with him since 2 days after he moved in. I will attach resident's behavior notes so that you can read all of the issues we have had with [resident's name]. There have been numerous MAARC reports and police reports filed. He has destroyed property, (we have had to replace the door to his room a few times, he breaks any dishes he is given, he has broken the radiator in his room, ect [sic]) assaulted staff and other residents. Even though we did go through the eviction process with him back in December 2022, we have been unable to find a new placement for him. He refuses all mental health appointments and has been refusing his medications. The Ombudsman was out to visit with [resident's name] yesterday. He said he would look into see where the Rule 20 evaluation is at. [Resident's name] continues to show aggression towards other residents and staff. We try to have a staff member present whenever [resident's name] is around other residents. But that is not always possible. We continue to try and find him new placement without any luck. Yes, I do believe he is a danger to be around the other residents. I'm not sure if Coordinated Care is the right option but it is worth a try. I am not sure that he will attend any appointments."	0 630			

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0 630	Continued From page 31 Response from provider dated July 27, 2024, noted "If he has a guardian - can he refuse appointments? Though I suppose you cannot force him into a vehicle for transport. I will place a CCC [coordinated care clinic] referral and additional referrals to SW [social work] for help. I think talking to lawyer first is most important". LALD replied that he is his own guardian and noted she had been trying the lawyer route. October 4, 2024, note from provider included the following orders: - increase Seroquel to 50 milligrams (mg) in the morning and 25 mg in the evening; - community connect referral placed; and - wheelchair order placed. On October 21, 2024, at 1:40 p.m., LALD-B stated regarding the incident reports the following: - February 14, 2024, looks like she missed that one for the investigation piece, and this would be completed by the LALD or CNS. LALD-B noted if they can get R4 to calm down and go to his room, they don't call the police. LALD-B stated the provider can only do so much with the psychiatric medications, and the Seroquel was increased the last time he was seen on October 4, 2024. LALD-B stated no new interventions were place after this incident; - April 14, 2024, LALD-B stated she did the investigation piece and noted no new interventions were put in place. LALD-B stated any new interventions would be noted under the comments section of the investigation area on the incident reports; - May 15, 2024, LALD-B stated it looks like she missed doing the investigation piece on this one. LALD-B stated it does not always pop up to let her know there is a new incident report to be	0 630			

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0 630	Continued From page 32 reviewed. LALD-B stated she did find out about and filed a MAARC report, but forgot to go in and do the investigation piece. No new interventions were put into place; - June 5, 2024, LALD-B stated the investigation piece was not completed, but they did implement the use of paper / plastic plates; - June 24, 2024, LALD-B stated a MAARC report was filed, but no new interventions were put into place. LALD-B added she was not sure what other new interventions could be put into place, or what other steps to take. LALD-B stated she had been updating the provider and looking for suggestions. They are recommending a psychiatric evaluation but R4 is refusing this. No new interventions implemented; - August 1, 2024, LALD-B stated she missed doing the investigation on this one as well. LALD-B stated a MAARC report was not filed since there was no injury. No new interventions implemented; - August 25, 2024, LALD-B stated she was notified and did the investigation, but no new interventions were implemented; - August 26, 2024, LALD-B stated a MAARC report was filed but no new interventions were implemented. LALD-B stated at this time they started to try to see about getting the motorized scooter removed, contacted R4's brother who was in favor of this, and emailed OOLTC but had not heard back. LALD-B stated she had also contacted Leading Age but they did not have an answer for her and suggested she reach out to OOLTC; and - September 20, 2024, LALD-B stated no investigation piece had been completed and she was on site for this incident. No new interventions implemented. At this time, the abuse prevention plan was	0 630			

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0 630	Continued From page 33 discussed, and LALD-B stated the scooter was relatively new, purchased for him by people in town. LALD-B stated no specific interventions were listed. LALD-B said R4 was homeless prior to coming to the facility, so there was no former facility to check with for interventions for behaviors tried in the past. In addition, LALD-B stated the charges were prior to July, so they should have been included on the vulnerability assessment. LALD-B also stated there was not much information for interventions on the service plan either, and she was working to get these more personalized. LALD-B stated they had discussed contract termination with R4, but they cannot find a safe place for him to go with his behaviors. LALD-B stated R4's case coordinator from UCARE has been in contact with her about this resident and R4's brother. They are in agreement that the motorized scooter should be removed. On October 23, 2024, at 10:55 a.m., clinical nurse supervisor (CNS)-A stated she is aware of the behaviors, and they are briefly noted in her assessment dated July 29, 2024. CNS-A stated she began working for the facility on July 22, 2024, and stated if there is a physical altercation she is to be notified, she reviews the incident reports and has a pile to review when she comes in on Tuesdays. Both LALD-B and CNS-A stated they had not received a call back from CCC to schedule an appointment and had not received information from the social work referral, and neither had made an attempt to follow up on this. CNS-A stated she has not contacted R4's provider to discuss the situation, and added she is waiting on the court ordered appointment. On October 24, 2024, at 10:00 a.m., LALD-B stated they did not dig into what may be causing	0 630			

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0 630	Continued From page 34 the anger issues. CNS-A stated she just included the current medical history as it contributes to the mental health piece of thing. Both LALD-B and CNS-A stated they do not feel this is the appropriate setting for R4. CNS-A stated R4 has been refusing cares and it is limited when she tries to see him with the refusals, making it hard to figure out how to move forward to treat him. Both stated a referral for physical and occupational therapy had not been received or requested to determine if the scooter was appropriate for R4. CNS-A stated the situations are different each time, and they are circling back with the same interventions to try and not adding anything new. CNS-A stated R4 needs to be seen but keeps refusing, and feels they are at a loss here of what to do. LALD-B stated it had been a while since the Rule 20 was ordered and CNS-A stated she was not sure what to do if R4 was refusing the Rule 20 and appointments. LALD-B stated they had tried to get him admitted for a psychiatric evaluation or a 72-hour hold , but were unable to do this, are told there is no room or a referral is needed for an evaluation. The sheriff has been called on a regular basis and VA reports were filed. LALD-B stated she did not know how R4 was returned on the forklift, and said she was not sure if staff went outside to help or just saw him from inside. R4 returned inside the building on his motorized scooter. In addition, LALD-B stated no MAARC report had been filed for this incident. Both LALD-B and CNS-A stated they felt R4 was a danger to himself and others. A review of R4's progress notes lacked documentation of attempts to obtain a psychiatric evaluation or a 72-hour hold. R5 R5's diagnoses included cerebral infarction	0 630			

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0 630	Continued From page 35 (stroke), type II diabetes mellitus, hypertension (high blood pressure), paranoid schizophrenia (affects a person's ability to think, feel, and behave clearly), dementia, and hyperlipidemia. R5's undated Service Plan Agreement indicated R5 received services including assistance with bathing, dressing, shaving, nail care, bed making, blood glucose monitoring, medication administration, and behavior management (Staff to document resident concerns and behaviors. Contact nurse with any emergent concerns. Provide assistance to monitor reactive behaviors in a supportive environment. Staff to document resident concerns and behaviors. Contact nurse with any emergent concerns). R5's Master Assessment Template dated August 20, 2024, noted R5 utilized a manual wheelchair, required verbal reminders for meal times but goes to the dining room independently, had moderate disorientation to person, place, or time. It noted visual/auditory hallucinations, and finishing off plates of house mates after they are done at meal times. R5's Vulnerability, Safety and Risk Assessment with Abuse Prevention Plan (identified as R5's Individual Abuse Prevention Plan/IAPP) dated August 20, 2024, noted vulnerabilities with interventions needed including: - vulnerable to abuse against them from others - due to dementia diagnosis, unlikely to report abuse/neglect. Facility staff are considered mandated reporters, and will monitor for signs of abuse/neglect and report to RN; - anxiety/depression - Diagnosis of dementia which can naturally cause anxiety and depression to appear - facility staff will monitor client for changes or concerns and report to RN; and	0 630			

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0 630	Continued From page 36 - able to ambulate safely with or without assistive devices or safe use of devices - displays generalized weakness, uses a four wheeled walker to ambulate. Also displays a left foot drop. It noted the assessment was based on interview with R5, observation and assessment of R5. It noted "Client [resident] does not appear to have any areas of vulnerability requiring intervention at this time. R5's IAPP did not indicate R5 was at risk of abuse from R4, nor any specific interventions or statements of specific measures taken to minimize risk of abuse. On October 25, 2024, at 7:45 a.m., CNS-A stated she is not made aware of incidents unless there is an injury. She stated she has heard there are incidents but has not done an assessment because there are no injuries. CNS-A stated no specific interventions are listed on vulnerability assessment regarding the vulnerability related to R5 and his motorized scooter. LALD-B stated one intervention they are doing is having a staff present in the dining room when both R4 and R5 are in there, but it does not always happen right away. When reviewing the reporting policy, both stated the RN is not being notified right away, and LALD-B stated this will change going forward. CNS-A and LALD-B stated no resident abuse prevention plans mention a vulnerability related to risk of abuse from R4. The licensee's Reporting, Documenting and Reviewing Incidents Involving Residents policy dated revised July 31, 2021, noted whenever an incident occurs involving a resident, staff shall immediately contact the RN. The RN will assess the incident and direct staff on how to proceed. The RN will review the incident report within 24 hours and investigate to determine if the incident needs to be reported through MAARC. The RN	0 630			

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0 630	Continued From page 37 will then discuss findings with the resident, resident's representative and/or staff and implement change to the environment or service plan as indicated. The licensee's Vulnerable Adult Maltreatment policy dated October 26, 2021, noted an abuse prevention plan would be completed for each resident and would include an individualized review or assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults, the risk of abusing other vulnerable adults, and specific measures to be taken to minimize the risk of abuse to others and self-abuse. No further information provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 630			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	0 650			

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0 650	Continued From page 38 reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for one of two employees (unlicensed personnel/ULP-C). 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-C started employment on March 1, 2015, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-C's employee record lacked documented evidence of: - annual performance reviews that identified areas of improvement needed and training needs.	0 650			

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0 650	Continued From page 39 On October 24, 2024, from 7:40 a.m. through 7:51 a.m., the surveyor observed ULP-C administer medications to three residents. On October 24, 2024, at 9:05 a.m., licensed assisted living director (LALD)-B stated ULP-C's annual review had not been completed and had been missed. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated January 4, 2024, noted the registered nurse was responsible for completing a performance review on each staff person annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660			

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0 660	Continued From page 40 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a current facility TB risk assessment. 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: The licensee's TB Risk Assessment was dated October 13, 2023, and indicated the licensee was a low risk for TB transmission. On October 24, 2024, at 8:45 a.m., licensed assisted living director (LALD)-B stated the assessment had not been completed in 2024. The licensee's TB Prevention and Control policy dated August 1, 2021, noted the licensee would complete a written TB risk assessment and an annual review and revision as needed. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July	0 660			

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0 660	Continued From page 41 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. 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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680			

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0 680	Continued From page 42 by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 21, 2024, at 9:20 a.m., during the initial tour of the facility with licensed assisted living director (LALD)-B, the surveyor observed the facility consisted of a two level building. The upper level consisted of several resident rooms, kitchen, dining room, office space, laundry room, shower room, and common areas for residents to sit. The lower level consisted of two bedrooms. The licensee's EPP binder dated reviewed on November 17, 2023, lacked the following required content: - quarterly review of the missing resident plan; - identification of at risk population needs like maintaining independence, communication, transportation, supervision, and medical care; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response;	0 680			

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0 680	Continued From page 43 - policy and procedure to address food, water, medical supplies, and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents; - alternate sources of energy to maintain temperatures to protect resident health and safety, safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, alarm systems, and sewage and waste disposal; - policy and procedure to include a system to track the location of on-duty staff and sheltered residents, and if on-duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure to address safe evacuation from the facility, including consideration of care and treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation locations, primary / alternative communication means with external sources of assistance; - policy and procedure to address the use of volunteers, including the process/role for integration; - policy and procedure to address the development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure to address the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - a written communication plan including: - the names and contact information of staff, entities providing services under agreement, residents' physicians, other facilities, and volunteers; - means to providing information about the facility's occupancy, needs, and its ability to	0 680			

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0 680	Continued From page 44 provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; - method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; - EP training and testing program that must be reviewed and updated annually; - training program to include initial training of new staff and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role and at least annually; - exercises to test the EP at least twice per year, including unannounced staff drills using the EP to include: - participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if the facility experiences an actual emergency requiring activation of the plan, the facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include a second full-scale exercise that is community based or an individual, facility based functional exercise or mock disaster drill or table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise the plan as needed. On October 25, 2024, at 10:30 a.m., LALD-B stated she probably should review the missing resident plan more than she does and she was not aware of the need to do this quarterly. LALD-B also stated the EPP was missing the above required content.	0 680			

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0 680	Continued From page 45 Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730			

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0 730	Continued From page 46 (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 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 a discharge summary with the required content for one of one resident (R3). In addition, the licensee failed to ensure documentation of all provided services was completed for one of two residents (R1) and failed to ensure the resident record included all	0 730			

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0 730	Continued From page 47 records of communication pertinent to the resident's services for one of one resident (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 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: DISCHARGE SUMMARY R3 admitted to the facility on June 1, 2022, and discharged on August 19, 2024. R3's diagnoses alcohol and recreational drug use. R3's Service Plan Agreement dated September 3, 2021, indicated R3 received assistance with dining reminders and preparation, housekeeping, and laundry. R3's record lacked documented evidence of a discharge summary to include: - a summary of the resident's stay that included diagnoses, course of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental and behavioral status. On October 21, 2024, at 12:25 p.m., licensed assisted living director (LALD)-B stated the	0 730			

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0 730	Continued From page 48 clinical nurse supervisor (CNS) was new and she did not think to ask her to do one. The licensee's Discharge Summary policy dated January 24, 2024, noted a discharge summary would include a summary of the resident's stay including diagnosis, courses of illnesses, allergies, treatments, therapies, pertinent lab consultation results, and a final summary of the resident's status. DOCUMENTATION OF SERVICES AND PERTINENT COMMUNICATIONS R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. On October 24, 2024, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-C provide medication administration to R1. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. R1's Service Delivery Record for September and October 2024 listed the service and the dates of the month. The record included a number in most of the spaces. However, it lacked documentation on September 20, 2024, and October 7, 2024. R1's Master Assessment Template dated February 3, 2024, indicated a change in condition and noted hospice care was initiated. R1's record lacked documentation of services provided by hospice or other communication with hospice pertinent to R1's services.	0 730			

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0 730	Continued From page 49 On October 23, 2024, at 11:10 a.m., LALD-B and CNS-A stated all services provided by staff should be signed off, and stated the numbers listed on the service delivery indicated the number of times provided by staff. In addition, LALD-B stated hospice staff used to have a binder with information and were better about checking in with facility staff with each visit, but it has not been good lately. The licensee's Clinical Records policy dated revised November 11, 2019, noted the clinical record would include documentation of communication/coordination pertinent to the resident's services. No further information was provided. TIME PERIOD FOR CORRECTION: 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	0 780			

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0 780	Continued From page 50 required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On October 21, 2024, at 8:30 a.m., upon arriving to the facility, the surveyor observed a pile of dried leaves along the brick ledge of the cement in front of the entrance, with a metal table over the leaves with a metal coffee can on top of the table. The surveyor observed the coffee can was two thirds full of extinguished cigarette butts and ashes on top of the leaves by the table, and ashes across on the other side of the cement. Both sides had chairs to sit on, and there were	0 780			

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0 780	Continued From page 51 leaves on both sides along the brick ledge. On October 24, 2024, at 8:05 a.m., the surveyor observed the metal coffee can to be two thirds full of cigarette butts with a cigarette pack on top of the extinguished butts. The pack had two extinguished cigarette butts on top of it, and the plastic on the cigarette pack was melted slightly. The surveyor observed a pile of leaves along both sides of the brick ledges of the cement in front of the entrance. The designated smoking area was not provided with fire-rated ashtrays, and the residents were using a metal coffee can. On October 23, 2024, at 10:35 a.m., licensed assisted living director (LALD)-B stated residents were not to place trash in the coffee can, and staff are to check a couple times a day to see the area where residents are smoking. LALD-B stated she was aware the leaves need to be cleaned up. In addition, LALD-B stated they started using the metal coffee can because they had a tall plastic butt receptacle, but residents were placing cigarettes in it without extinguishing it, and it started to melt. TIME PERIOD FOR CORRECTION: Two (2) day	0 780			
0 910 SS=B	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:	0 910			

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0 910	Continued From page 52 (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: 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 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). 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 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 lacked a written contract with the following required content: - the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility; and - identification of the authorized agent. R1's diagnoses included Alzheimer's disease,	0 910			

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0 910	Continued From page 53 major depressive disorder, osteoporosis, incontinence, and insomnia. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. R1's Lease Agreement dated September 27, 2022, noted on page 9, licensed assisted living director (LALD)-B's name, address, and phone number. On October 25, 2024, at 8:05 a.m., LALD-B stated the same template was used for all but one resident, and it lacked the HFID number. In addition, it lacked the identification as herself as the authorized agent. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 920 SS=B	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional	0 920			

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0 920	Continued From page 54 fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a contract with the required content for one of one resident (R1). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation.	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28686	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 231 WASHINGTON STREET HOLDINGFORD, MN 56340		
(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
0 920	Continued From page 55 R1's Lease Agreement dated September 27, 2022, lacked a delineation and description of any additional fees the resident may be required to pay if the resident's condition changed during the term of the contract. On October 25, 2024, at 8:05 a.m., licensed assisted living director (LALD)-B stated the same template was used for all but one resident, and the contract lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920			
0 930 SS=B	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;	0 930			

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0 930	Continued From page 56 (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. R1's Lease Agreement dated September 27, 2022, lacked a clear and conspicuous notice of: - the right under section 144G.54 to appeal the termination of an assisted living contract; and - the facility's policy regarding transfer of residents within the facility, under which resident consent is required for a transfer. On October 25, 2024, at 8:05 a.m., licensed assisted living director (LALD)-B stated the same	0 930			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28686	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2024
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0 930	Continued From page 57 template was used for all but one resident, and the contract lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930			
0 940 SS=B	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance	0 940			

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0 940	Continued From page 58 waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. R1's Lease Agreement dated September 27, 2022, lacked a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I,	0 940			

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0 940	Continued From page 59 including: - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On October 25, 2024, at 8:05 a.m., licensed assisted living director (LALD)-B stated the same template was used for all but one resident, and the contract lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940			

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0 950	Continued From page 60	0 950			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for two of two residents (R1, R2).	0 950			

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0 950	Continued From page 61 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. R1's record contained an undated Designation of Representative form which included the required verbiage. However, the form lacked a signature by the resident indicating the designation of representative or a note R1 declined. R2 R2's diagnoses included peripheral vascular disease, alcohol dependence, generalized idiopathic epilepsy, and anemia. R2's Service Plan Agreement dated May 17, 2023, indicated R2 received services including dining reminders, nail care, and bed making. However, it lacked a signature by the licensee to document agreement on the services to be provided. R2's record contained an undated Right To	0 950			

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0 950	Continued From page 62 Designate a Representative for Certain Purposes form with the required verbiage. However, it lacked a signature by the resident indicating the designation of representative or a note R2 declined. On October 25, 2024, at 8:05 a.m., licensed assisted living director (LALD)-B stated the required verbiage was included with the contract, but said she was not sure why the form was not completed by residents or signed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
0 970 SS=B	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 970			

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0 970	Continued From page 63 a minimal impact on the resident and does not affect health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: The licensee's undated Lease Agreement included the following clause on page 9: - "Insurance Liability and Release. The Resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverage and shall provide evidence of same by copies of binders or policies provided to Hyatt House upon request. The Resident acknowledges that Hyatt House is not an insurer of the Resident's person or property. The Resident agrees that Hyattt House will not be liable to the Resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of Resident) suffered by the Resident or the Resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of the Hyatt House or its employees or agents. The Resident hereby releases Hyatt House from liability for any personal injury or property damage suffered by the Resident or the Resident's agents, guests, or invitees, unless caused by the negligence of Hyatt House or its employees or agents." On October 25, 2024, at 8:05 a.m., licensed assisted living director (LALD)-B stated the same template of the contract is utilized for all but one resident, and it contains a waiver of liability.	0 970			

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0 970	Continued From page 64 LALD-B said she was not aware this should not be included in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all employees with access to residents and resident records had a cleared background study completed via NetStudy 2.0 for one of three employees (clinical nurse supervisor/CNS-A). This had the potential to affect all residents, employees, and visitors. This practice resulted in a level three violation (a	01290			

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01290	Continued From page 65 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: This resulted in an immediate correction order on October 23, 2024. CNS-A was hired on July 22, 2024, to provide direct care services to residents of the facility. CNS-A's employee record lacked documentation of a cleared background study. Review of the licensee's Employee Roster provided by the sensitive information person (licensed assisted living director/LALD)-B did not include CNS-A's name. CNS-A obtained her RN license on November 26, 2013. On October 22, 2024, during the survey, the surveyor observed CNS-A interacting with residents and having access to resident records, without direct supervision. On October 23, 2024, at 1:40 p.m., LALD-B provided the background study Employee Roster, stated CNS-A was not on the list, and said she must have not done a background study for her. The licensee's Background Checks policy dated August 1, 2021, noted all employees must pass a background study. No further information was provided.	01290			

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01290	Continued From page 66 TIME PERIOD FOR CORRECTION: IMMEDIATE	01290			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing	01470			

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01470	Continued From page 67 services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of two employees (clinical nurse supervisor/CNS-A). 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:	01470			

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01470	Continued From page 68 CNS-A was hired on July 22, 2024, to provide direct care services to residents of the facility. CNS-A's employee record lacked documented evidence of the following required orientation: - overview of the assisted living statutes; - review of the provider's policies and procedures; - handling emergencies and using emergency services; - handling of resident complaints, reporting of complaints, and where to report complaints; - consumer advocacy services; - review of the types of assisted living services the employee would provide and the provider's scope of license; and - principles of person-centered planning and service delivery. On October 24, 2024, at 8:45 a.m., licensed assisted living director (LALD)-B stated CNS-A should have had all orientation topics completed and was not sure why some were missing. The licensee's Assisted Living & Assisted Living with Memory Care Orientation - All Staff policy dated January 11, 2024, noted all assisted living employees must complete an orientation to assisted living licensing requirements and regulations before providing services to residents, and noted the orientation would include an overview of the assisted living laws, an introduction to the provider's policies and procedures related to the provision of services, emergency and disaster training, complaint process, Office of Health Facility Complaints, contact information for the Office of the Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Disabilities, the types of services as indicated on the uniform Disclosure of Assisted Living Services and	01470			

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01470	Continued From page 69 Amenities and the provider's scope of licensure, and principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures	01500			

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01500	Continued From page 70 relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel/ULP-C). 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	01500			

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01500	Continued From page 71 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: ULP-C started employment on March 1, 2015, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-C's employee record lacked documented evidence of the following required annual training: - principles of person-centered planning/service delivery. On October 24, 2024, from 7:40 a.m. through 7:51 a.m., the surveyor observed ULP-C administer medications to three residents. On October 24, 2024, at 9:05 a.m., licensed assisted living director (LALD)-B stated principles of person-centered training was not provided to any employees as required. The licensee's Assisted Living Annual Training policy dated January 11, 2024, noted all employees would complete annual training including principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			

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01530	Continued From page 72	01530			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee (clinical nurse supervisor/CNS-A) received the required amount of dementia care training to include the required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530			

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01530	Continued From page 73 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: The licensee had a current assisted living facility with dementia care license. CNS-A was hired on July 22, 2024, to provide direct care services to residents of the facility. CNS-A's employee record contained evidence of eight hours dementia training. However, it lacked evidence of dementia training to include person-centered planning and service delivery. On October 24, 2024, at 8:45 a.m., licensed assisted living director (LALD)-B stated the licensee was not providing person-centered planning and service delivery training for any staff at this time. The licensee's Assisted Living Dementia Training policy dated January 11, 2024, noted dementia training would include person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620			

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01620	Continued From page 74 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all areas of the uniform assessment tool as required per Minnesota Administrative Rule 4659.0150 were addressed for two of two residents (R1, R2) and failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 days, as required, for two of two residents (R1, R2). In addition, the licensee failed to assess residents after a fall and develop and implement new interventions related to the root cause of falls for two of two residents (R1, R2).	01620			

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01620	Continued From page 75 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: COMPREHENSIVE ASSESSMENT R1 R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. On October 24, 2024, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-C provide medication administration to R1. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. R1's record contained a Master Assessment Template dated May 3, 2024, and September 10, 2024, (130 days after the last assessment). R2 R2's diagnoses included peripheral vascular disease, alcohol dependence, generalized idiopathic epilepsy, and anemia. R2's Service Plan Agreement dated May 17, 2023, indicated R2 received services including dining reminders, nail care, and bed making.	01620			

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01620	Continued From page 76 R2's record contained a Master Assessment Template dated April 5, 2024, and August 27, 2024, (144 days after the last assessment). R1 and R2's assessments lacked the following required content: - personal lifestyle preferences including sleep schedule, advanced health care directives and end-of-life preferences, including whether a person has or wants to seek a do not resuscitate (DNR); - infectious conditions; - a review of medications according to Minnesota (MN) statutes, section 144G.71, subd. 2, including the reason taken, any side effects, contraindications, allergic or adverse reactions, and actions to address those issues, dosage, frequency of use, route administered, and any difficulties the resident faces in taking the medication; - weight; - nutritional and hydration preferences; - who has decision-making authority for the resident including the presence of any advanced health care directive or other legal document that established a substitute decision maker (SDM), and the scope of decision-making authority of a SDM; and - the need for follow-up referrals for additional medical or cognitive care by health professionals. On October 23, 2024, at 11:10 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the same assessment template was utilized for all residents and it lacked the above required content. In addition, LALD-B stated there had been an interim CNS who was not completing the tasks required causing the assessments to be late.	01620			

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01620	Continued From page 77 Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. The licensee's Initial and On-going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy dated June 1, 2021, noted the RN would complete a comprehensive nursing assessment no more than every 90 days and the assessment would include the requirements outlined by Minnesota rules to include the resident's sleep schedule, advanced health care directives and end-of-live preferences, including whether a person has or wants to seek DNR, infectious conditions, medication review including the reason taken, any side effects, contraindications, allergic or adverse reactions, and actions to address those issues, dosage, frequency of use, route administered or taken, and any difficulties taking medications, nutritional and hydration status and preferences, presence of any advanced health care directive	01620			

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01620	Continued From page 78 or other legal document that established a SDM, scope of the decision-making authority of SDM, and the need for follow-up referrals for additional medical or cognitive care by health professionals. FALLS R1 R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. On October 24, 2024, at 7:51 a.m., the surveyor observed ULP-C provide medication administration to R1. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. R1's Resident Incident Reports noted the following: - February 19, 2024, at 1:30 p.m., resident was found on the floor in front of her chair in the dining room and did not say what happened. It noted R1 had hit her head, staff helped her into the chair and let her sit for a few minutes before walking with resident to her room and assisted into bed. The incident report incident investigation by LALD-B which included in the comments section "Resident has a tendency [sic] of falling asleep at the table. Staff usually catches her sleeping and helps her to her room. He was awake and alert [sic] a few minutes before the incident." The report lacked RN notification. - March 21, 2024, at 10:45 a.m., resident was yelling and staff walked into the bathroom and found resident on the floor. Staff called for another staff, took resident's vital signs, did range	01620			

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01620	Continued From page 79 of motion, and checked for injuries. Staff then assisted resident to the chair. No injuries were noted. The incident report incident investigation completed by LALD-B noted resident had become increasingly unsteady on her feet, and noted it was discussed with hospice. It included in the comments section "Use of walker discontinued, walker stored away in closet. Staff will help resident get around with her wheelchair." The form lacked RN notification. - July 17, 2024, at 4:45 p.m., resident had a witnessed fall in the dining room, trying to pick up a fork from the floor and fell back against the wall. No injuries were noted. R1 was assisted back to her wheelchair after assessing for injuries. The incident report incident investigation completed by LALD-B noted resident had a history of falls, and the comments section noted "Will discuss with Hospice and PCP (primary care provider). Talk about use of tab alarm." The form lacked RN notification. - August 18, 2024, at 4:30 p.m., resident was found on the floor in the bedroom of her apartment. Resident was reassured and vital signs were taken before assisting her to the wheelchair with brakes on and alarm attached. Staff remained with resident until management arrived. The incident report incident investigation completed by LALD-B noted R1 often tried to stand and falls. It noted a history of falls, impaired mental status, impaired safety judgement, use of assistive devices, vision and hearing deficits, and weakness. It noted staff training was held and the comments section noted "Staff trained to ensure that breaks are on wheelchair and tab alarm applied." The form lacked RN notification. On October 23, 2024, at 11:10 a.m., CNS-A	01620			

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01620	Continued From page 80 stated she is not notified of all falls, and it depends on the situation. CNS-A stated most falls would include notification to the provider, and this was not completed. In addition, CNS-A stated after R1's last fall on August 18, 2024, an assessment was not completed until September 10, 2024. CNS-A was not sure when she was notified of the fall on August 18, 2024, and stated sometimes LALD-B tells her about falls that have happened when she comes in once a week and sometimes there are incident reports for her to look at when she comes in. In addition, LALD-B and CNS-A stated R1's provider was not notified of the falls. R2 R2's diagnoses included peripheral vascular disease, alcohol dependence, generalized idiopathic epilepsy, and anemia. R2's Service Plan Agreement dated May 17, 2023, indicated R2 received services including dining reminders, nail care, and bed making. R2's Resident Incident Reports noted the following: - February 6, 2024, at 5:15 p.m., R2 stood up to enter the building with hands full of groceries. It noted R2 was intoxicated, lost balance, and fell on the concrete on his left side. It noted staff ran to R2 and assisted him to a chair. R2 stated nothing hurt, and vital signs were taken. Staff assisted R2 to his wheelchair and helped him to his room. It noted a bruise was found on the left forehead. The incident report incident investigation completed by LALD-B noted under the comments section "Whenever resident goes out to drink he seems to always fall when he returns." The form lacked RN notification.	01620			

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01620	Continued From page 81 - July 3, 2024, at 6:30 p.m., R2 told staff he was trying to walk up the hill to get back to the facility and fell. A peer told staff they had found R2 after falling and had helped R2 up and brought him back to the facility on their scooter. Resident refused vital signs and stated he was fine. No injuries were noted. The incident report incident investigation completed by LALD-B noted under the comments section "Will be reviewed at Quarterly QA Meeting." The form lacked RN notification. - July 8, 2024, at 8:30 p.m., R2 found a fresh bruise on R2's forehead above his left eye and a bloody scab on the elbow. Under injuries noted "Bruise found, Hit head, Skin tear, Swelling." It notes staff provided emotional support, resident refused all other help. The incident report incident investigation completed by LALD-B noted resident had a history of falls when drinking alcohol and refusing care from staff. It noted under the comments section "Will be reviewed at Quarterly QA Meeting." The form lacked RN notification. - September 11, 2024, at 10:00 a.m., Staff found R2 on the floor in his room. R2 said he woke up on the floor. Staff observed a bump on the right side of the forehead above his eye and small skin tear on the nose. A skin tear was also noted on the left forearm. The form was completed by LALD-B, but the incident investigation was not completed. The form lacked RN notification. On October 23, 2024, at 12:05 p.m., CNS-A stated she was positive she was notified of the incident on September 11, 2024, the only one that occurred after she started working for the licensee. In addition, CNS-A stated she did not do an assessment after the fall per the fall protocol.	01620			

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NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 231 WASHINGTON STREET HOLDINGFORD, MN 56340		
(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 82 In addition, LALD-B and CNS-A stated the provider had not been notified of the falls. The licensee's undated Fall Protocol noted: - "Whenever a fall occurs, staff present shall immediately contact the RN. Guidance will be given based on the type of fall. Staff present will take any emergency actions necessary for the resident and will complete an incident report as soon as possible. A full set of vital signs are to be obtained - RN will assess the incident and direct staff how to proceed, i.e.. Deciding if emergency aid is needed - RN/LALD to review incident report and complete the investigation portion of the report - RN/LALD to contact family, provider, case managers as needed - RN to assess resident to see if services need to be added to service plan - Incident reports will be maintained in the resident's record and will be reviewed at quarterly QA [quality assurance] meetings." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The	01640			

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01640	Continued From page 83 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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the licensee to document agreement on the services to be provided for three of three residents (R1, R2, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included Alzheimer's disease,	01640			

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01640	Continued From page 84 major depressive disorder, osteoporosis, incontinence, and insomnia. On October 24, 2024, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-C provide medication administration to R1. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. However, it lacked a signature by the licensee to document agreement on the services to be provided. R2 R2's diagnoses included peripheral vascular disease, alcohol dependence, generalized idiopathic epilepsy, and anemia. R2's Service Plan Agreement dated May 17, 2023, indicated R2 received services including dining reminders, nail care, and bed making. However, it lacked a signature by the licensee to document agreement on the services to be provided. R4 R4's diagnoses included hypertension, partial traumatic amputation at knee level to the left leg, phantom limb syndrome with pain, personality and behavioral disorders, current alcohol and recreational drug use. R4's Service Plan Agreement dated April 24, 2023, indicated R4 received services including transportation assist, bathing setup, dining reminders, assistance with compression stockings, assistance with nail care, setup for grooming, daily blood pressure, bed making, housekeeping, laundry, medication	01640			

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01640	Continued From page 85 administration, monitoring alcohol use, and behavior management ("The community to provide assistance to monitor reactive behaviors in a supportive environment. Monitor and chart behaviors with other residents. The community to provide assistance to monitor reactive behaviors in a supportive environment"). However, it lacked a signature by the licensee to document agreement on the services to be provided. On October 23, 2024, at 11:10 a.m., licensed assisted living director (LALD)-B stated the service plans should be signed by her and her process was to review it with the resident and their family member as applicable and the sign it before it goes into the resident's chart. The licensee's Contents of Service Plans policy dated March 12, 2024, noted the service plans would have a signature or other authentication by the facility and by the resident. 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;	01650			

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01650	Continued From page 86 (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a service plan included the required content for two of two residents (R1, 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 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	01650			

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01650	Continued From page 87 R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. On October 24, 2024, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-C provide medication administration to R1. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. However, it lacked: - the fees for services; and - identification of and information as to who has authority to sign for the resident in an emergency. R2 R2's diagnoses included peripheral vascular disease, alcohol dependence, generalized idiopathic epilepsy, and anemia. R2's Service Plan Agreement dated May 17, 2023, indicated R2 received services including dining reminders, nail care, and bed making. However, it lacked: - the fees for services; and - identification of and information as to who has authority to sign for the resident in an emergency. On October 23, 2024, at 11:10 a.m., licensed assisted living director (LALD)-B stated the service plans did not include the fees for services, and stated it included a space to indicate if the primary emergency contact was authorized to sign on the resident's behalf, but often gets missed. The licensee's Contents of Service Plans policy dated March 12, 2024, noted the service plan	01650			

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01650	Continued From page 88 would include the fees for services and the identification of and and information on who had authority to sign for the resident in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures	01690			

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01690	Continued From page 89 must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction of a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 21, 2024, at 8:45 a.m., licensed assisted living director (LALD)-B stated the licensee provided medication management services to the licensee's residents. The licensee's policies lacked: - educating residents and legal and designated representatives about medications. On October 24, 2024, at 9:28 a.m., LALD-B stated she was not able to locate the above required policy.	01690			

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01690	Continued From page 90 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01690			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01700			

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01700	Continued From page 91 review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for two of two residents (R1, R2) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on October 21, 2024, at 8:45 a.m., licensed assisted living director (LALD)-B stated the licensee provided medications management services to residents at the facility. R1 R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. On October 24, 2024, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-C provide medication administration to R1. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. R1's prescriber orders dated August 16, 2024,	01700			

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01700	Continued From page 92 included one diuretic, one antidepressant, and two pain relievers. R1's Master Assessment Template dated September 10, 2024, lacked a medication assessment to include: - an identification and review of all medications the resident is known to be taking; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions; and - actions to address these issues. R1's October 2024, Medication Administration Record (MAR) listed medications as prescribed, times to administer, and staff initials on each date to indicate the medications had been given. R2 R2's diagnoses included peripheral vascular disease, alcohol dependence, generalized idiopathic epilepsy, and anemia. On October 24, 2024, at 9:40 a.m., the surveyor observed ULP-C provide medication administration to R2. R2's Service Plan Agreement dated May 17, 2023, indicated R2 received services including dining reminders, nail care, medication management, and bed making. R2's Master Assessment Template dated August 27, 2024, lacked a medication assessment to include: - an identification and review of all medications the resident is known to be taking; - indications for medications; - side effects;	01700			

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01700	Continued From page 93 - contraindications; - allergic or adverse reactions; and - actions to address these issues. On October 23, 2024, at 12:05 p.m., clinical nurse supervisor (CNS)-A stated the above information had not been included in the assessment for any resident and she was not aware of need to include this as part of assessment. The licensee's Medication Supply policy dated November 23, 2016, noted the registered nurse (RN) assessed the resident medications on admission to the medication management program. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760			

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01760	Continued From page 94 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per manufacturer instructions for one of one resident (R6), and failed to verify accuracy of prescriber orders when transcribing orders for one of one 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 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: MEDICATIONS NOT ADMINISTERED PER MANUFACTURER INSTRUCTIONS R6's diagnoses included traumatic brain injury (TBI). On October 24, 2024, at 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-C prepare R6's insulin for administration by dialing the pen to 1 unit, wasting the insulin, and dialing to the prescribed dose of 22 units. After exiting R6's room, ULP-C stated she had dialed the pen to 1 unit to prime the pen. R6's undated Service Plan Agreement noted services including insulin administration. R6's prescriber orders dated May 1, 2024, included Novolin 70/30 FlexPen inject 22 units	01760			

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01760	Continued From page 95 daily in the morning. On October 25, 2024, at 10:00 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the pen should be primed by dialing to 2 units and wasting, not 1 unit. The manufacturer's instructions for use instructed to turn the dose selector to 2 units, and press the push-button all the way until the dose selector returns to 0, then turn the dose selector to the number of units to be injected. ORDER TRANSCRIPTION R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. On October 24, 2024, at 7:51 a.m., the surveyor observed ULP-C provide medication administration to R1. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. R1's prescriber orders dated August 16, 2024, included: - hydromorphone 2 milligrams (mg) take one tablet by mouth every 1 hour as needed for pain (PRN). R1's October 2024, Medication Administration Record (MAR) included: - hydromorphone 2 mg give one tablet by mouth every morning at 6:30 a.m.	01760			

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01760	Continued From page 96 On October 23, 2024, at 11:10 a.m., LALD-B stated she had transcribed the orders on the MAR and had added one of the PRN doses to be administered at 6:30 a.m. to help resident in the morning, and added there was no order for this. In addition, LALD-B stated she was not a nurse. CNS-A stated she was not aware this had been done. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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 observation, interview and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication setup by licensed assisted living director (LALD)-B for one of one resident (R1); and failed to ensure documentation of medication setup included all the required content for one of one resident (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	01770			

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NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 231 WASHINGTON STREET HOLDINGFORD, MN 56340			
(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
01770	Continued From page 97 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 21, 2024, at 8:45 a.m., during the entrance conference, LALD-B stated if the nurse is unable to do the medication setup, she does this task. LALD-B stated she was trained to do this by a previous nurse and stated she is not a nurse. R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. On October 24, 2024, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-C pour medications for R1 from a pill box (a multicompartiment compliance aid for storing scheduled doses of medication). R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration including medication setup, and ambulation. R1's prescriber orders dated August 16, 2024, included one diuretic, one antidepressant, and two pain relievers. R1's record lacked documentation of medication setup to include: - dates of medication setup; - name of medication; - quantity of dose;	01770			

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01770	Continued From page 98 - times to be administered; - route of administration, and - name of person completing medication setup. On October 25, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated she was aware LALD-B was doing medication setup and added she was going to make some changes to their process. CNS-A stated if she was training staff to do this task, she feels it would be within their scope of practice to do so. According to the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by:	01820			

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01820	Continued From page 99 Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two 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 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: During the entrance conference on October 21, 2024, at 8:45 a.m., licensed assisted living director (LALD)-B stated the licensee provided medications management services to residents at the facility. R1's record lacked prescriber orders for: - discontinue melatonin; and - vitamin D3. R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. On October 24, 2024, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-C provide medication administration to R1. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation.	01820			

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01820	Continued From page 100 R1's prescriber orders dated August 16, 2024, included: - melatonin 3 milligram (mg) tablets, take 2 tablets by mouth at bedtime. R1's Medication Administration Record (MAR) for October 2024, included vitamin D3 25 micrograms (mcg) take one tablet by mouth daily. The MAR lacked melatonin. On October 23, 2024, at 11:10 a.m., LALD-B and clinical nurse supervisor (CNS)-A stated the melatonin had been discontinued but they had not received a signed order for this. In addition, they stated there was no order for the vitamin D3. The licensee's Documenting Medication Management Activities policy noted the registered nurse (RN) would work with the pharmacy to reconcile medications, coordinate delivery, and obtain or verify prescription orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=D	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	01880			

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01880	Continued From page 101 review, the licensee failed to ensure medications were stored according to the manufacturer's recommendations for one of one resident (R1) with liquid Ativan. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 23, 2024, at 1:15 p.m., the surveyor observed medication storage with unlicensed personnel (ULP)-C and licensed assisted living director (LALD)-B. The locked narcotic box contained a Ziploc bag with faint writing on it with a marker with R1's name, medication name, and partial directions for use. The bag contained 12 prefilled syringes without any type of identification label on them. At this time, ULP-C and LALD-B stated this is contained liquid Ativan for R1, which was drawn up from a vial into the syringes by clinical nurse supervisor (CNS)-A or the hospice nurses, and they did not know if the medication needed to be stored at a certain temperature. ULP-C then opened a safe in the wall which contained one unopened and one opened vial of liquid Ativan. On October 24, 2024, at 10:00 a.m., CNS-A stated the liquid Ativan is a cold medication and should be stored in the refrigerator. R1's October 2024 Medication Administration	01880			

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01880	Continued From page 102 Record (MAR) noted R1 received liquid Ativan on September 17, 2024. The manufacturer's undated instructions for lorazepam oral concentrate (liquid Ativan) noted to store at 36 - 46 degrees Fahrenheit. The licensee's Storage of Medications policy dated December 1, 2021, noted medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods, and temperature is maintained at 35 - 40 degrees Fahrenheit. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	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 bearing a prescription label with legible information for one of one resident with liquid lorazepam (R1), failed to date time-sensitive medications with an open date for one of one resident (R6), and failed to monitor for expired medications for one of one resident (R6).	01890			

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01890	Continued From page 103 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 21, 2024, at 8:45 a.m., licensed assisted living director (LALD)-B stated the licensee provided medications management services to residents at the facility. On October 23, 2024, at 1:15 p.m., the surveyor observed the licensee's medication storage area with unlicensed personnel (ULP)-C and LALD-B, and noted the following: - 12 unlabeled syringes in a plastic bag written on the bag with a marker lorazepam and R1's name, all faded; - Novolin 70/30 FlexPen not dated when opened for R6; and - Novolog dated opened 8/11/24 for R6. R1's liquid lorazepam lacked a prescription label with legible information. R6's Novolin 70/30 FlexPen lacked a date when opened. R6's Novolog FlexPen was dated opened on August 11, 2024. On October 25, 2024, at 10:00 a.m., clinical nurse	01890			

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01890	Continued From page 104 supervisor (CNS)-A and LALD-B stated the lorazepam syringes were being set up by hospice, not CNS-A, and said the syringes were not labeled with the required information. In addition, CNS-A stated all insulin pens were to be labeled with the date they were opened, and the Novolog dated August 11, 2024, would be expired and should not be used. The manufacturer's instructions for use for Novolin 70/30 FlexPen dated June 2022, noted an opened in-use pen can only be used for a total of 10 days after opening. The manufacturer's instructions for use for Novolog FlexPen dated December 2012, noted opened pens are good for 28 days once opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
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	01940			

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01940	Continued From page 105 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 treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1). In addition, the licensee failed to include the treatment services on the service plan as required for one of one resident (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). Findings include:	01940			

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01940	Continued From page 106 During the entrance conference on October 21, 2024, at 8:45 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment management services to residents. R1's record lacked a treatment management plan to include the following required content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. On October 24, 2024, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-C provide medication administration to R1. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. R1's prescriber orders dated July 17, 2024, included oxygen continuously at 1-3 liters per	01940			

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01940	Continued From page 107 minute (LPM) via nasal cannula. R1's MN [Minnesota] Medication Treatment Therapy Management Plan dated September 10, 2024, noted services being provided including medication reminders, medication setups, and administration of medications. However, it lacked the identification of oxygen management. On October 23, 2024, at 11:10 a.m., clinical nurse supervisor (CNS)-A stated the oxygen management was not included on the treatment management plan or the service plan as required. The licensee's Treatment and Therapy Management policy dated April 28, 2017, noted the registered nurse (RN) would prepare an individualized care plan including a treatment plan including the type of services to be provided, procedures for documenting treatment or therapy, procedures for monitoring treatments to prevent possible complications or adverse reactions, identification of treatment tasks delegated to unlicensed personnel, and protocols of notifying the RN when problems arose related to the treatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
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	01970			

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01970	Continued From page 108 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 two residents (R1) who received treatments managed be the provider. 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 October 21, 2024, at 8:45 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment management services to residents. R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. On October 22, 2024, at 11:00 a.m., the surveyor observed R1 in her wheelchair in the upper area by the television room with a nasal cannula tubing in her nose and an oxygen tank on the back of her wheelchair. The oxygen tank was in the off position at this time, and verified with LALD-B.	01970			

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01970	Continued From page 109 R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. However, it lacked information on the oxygen management. R1's prescriber orders dated July 17, 2024, included oxygen continuously at 1-3 liters per minute (LPM) via nasal cannula. R1's MN [Minnesota] Medication Treatment Therapy Management Plan dated September 10, 2024, noted services being provided including medication reminders, medication setups, and administration of medications. However, it lacked the identification of oxygen management. On October 23, 2024, at 11:10 a.m., clinical nurse supervisor (CNS)-A and LALD-B stated there had been discussion by hospice about using the oxygen as needed for comfort on October 17, 2024, but the order was not updated. The licensee's Treatment and Therapy Management policy dated April 28, 2017, noted nursing would obtain orders for all treatment and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310			

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02310	Continued From page 110 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 one of one resident (R1) with an assistive device. This resulted in an immediate order for correction on October 22, 2024. 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: On October 22, 2024, at 9:20 a.m., the surveyor observed R1's bed with clinical nurse supervisor (CNS)-A. The bed was observed to have bilateral circular white metal bar with a horizontal bar through the middle, three vertical metal bars from the lower half, and two angled bars on the top half. The bars were securely attached to the bed frame. There was a green sticker attached to the left device that noted it was a Halo device. The device on the left side of the bed was raised in a higher position than on the right side of the bed, and pulled out without pushing the pin when moved by CNS-A. At this time, CNS-A stated R1 got the device last week and stated staff notified	02310			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 111 her probably the day after they were installed, but she had not done an assessment until today. CNS-A stated she did not know who installed them and would have to check with licensed assisted living director (LALD)-B. In addition, CNS-A stated she did not have the manufacturer guidelines and had not checked for a recall. R1's diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, incontinence, and insomnia. R1's Service Plan Agreement dated April 19, 2023, indicated R1 received services including assistance with bathing, medication administration, and ambulation. R1's Master Assessment Template dated September 10, 2024, indicated R1 had fallen out of bed with no injuries, required physical assist of one for getting in and out of bed, was incontinent of bowel and bladder, required verbal reminders to wear glasses, had significant orientation concerns that required redirection due to Alzheimer's disease, had hallucinations and spends a majority of time in the apartment. It noted R1 had trouble with dizziness and unsteady gait/problems with balance, had lower extremity weakness, and utilized oxygen. It indicated a fall risk of 4, which indicated a high risk for falls. It noted R1 had symptoms of arthritis such as pain or decreased joint mobility. On October 22, 2024, at 10:07 a.m., LALD-B stated CNS-A had contacted hospice to get the manufacturer guidelines, and stated hospice had provided and installed the device. On October 22, 2024, at 10:50 p.m., LALD-B and CNS-A provided the manufacturer guidelines for	02310			

Minnesota Department of Health

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02310	Continued From page 112 the Halo Safety Ring. They stated hospice will be coming later today to look at the device again. In addition, they stated they had not checked the Consumer Product Safety Commission (CPSC) for a recall and were not familiar with the site. R1's record lacked evidence the licensee had installed the device securely to the bed according to manufacturer guidelines, had referred to the CPSC to check for recall information. It lacked an assessment to include the condition and description of the device, whether the device had the effect of being an improper restraint, the purpose and intention of the device, the resident's device use and need, and the resident's preferences. It also lacked risk versus benefit discussion and documentation. The licensee's undated Bed Rail policy noted the administrator and clinical leadership would be responsible for ensuring the completion of individual bed rail assessments on a regular basis, and would provide education to the resident/personal representative pertaining to the risks and benefits . The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CPSC) for the most up-to-date information related to portable bed side rail recall information." The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going	02310			

Minnesota Department of Health

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02310	Continued From page 113 assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310			
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for medication setup for one of one employee (licensed assisted living director (LALD)-B). 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	02320			

Minnesota Department of Health

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02320	Continued From page 114 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: During the entrance conference on October 21, 2024, at 8:45 a.m., LALD-B stated the licensee provided medication management services to residents including medication setup for some residents. In addition, LALD-B stated if the nurse was not available when the medication setup was due to be completed, she does this and was trained by a former nurse. In addition, LALD-B stated she was not a nurse. On October 24, 2024, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-C pour medications for R1 from a pill box (a multicompartiment compliance aid for storing scheduled doses of medication). On October 24, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated she was aware LALD-B was completing medication setup for residents, and was making a few changes in their process. CNS-A stated she wanted to be notified of this being done, and stated if LALD-B was trained by a nurse it should be within her scope of practice to do so. LALD-B and CNS-A stated no documentation of medication setup was being completed. According to the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical	02320			

Minnesota Department of Health

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02320	Continued From page 115 decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all three current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a	03090			

Minnesota Department of Health

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03090	Continued From page 116 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: Upon entrance on October 21, 2024, at 8:30 a.m., the surveyor observed a sign outside the front entrance. A sign was on the glass that noted "Building and property under video surveillance." However, it lacked the required verbiage to include: - "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." On October 25, 2024, at 8:00 a.m., licensed assisted living director (LALD)-B stated the sign did not contain the same verbiage as in the statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090			

Type: Full
Date: 10/21/24
Time: 11:45:58
Report: 1037241253

Food and Beverage Establishment Inspection Report

Page 1

Location:

Hyatt House Llc
231 Washington Street
Holdingford, MN56340
Stearns County, 73

Establishment Info:

ID #: 0037490
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207469902
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.

4-500 Equipment Maintenance and Operation

4-501.114C1 **** Priority 1 ****

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

ORDER ORIGINALLY WRITTEN ON 8/17/21.

10/21/24 CHLORINE MEASURED 10 PPM AT THE TIME OF INSPECTION. MAINTAIN THE CHLORINE RINSE CONCENTRATION IN THE DISHWASHER AT 50-100 PPM. USE 3 COMPARTMENT SINK TO SANITIZE DISHES UNTIL DISHWASHER IS REPAIRED.

Comply By: 10/28/24

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. PROVIDE A CHLORINE TEST KIT TO MEASURE THE SANITIZING SOLUTION.

Comply By: 10/25/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment. ANGIE'S CERTIFIED FOOD PROTECTION MANAGER (CFPM) CERTIFICATE EXPIRED 9/19/22. EMPLOY A CFPM. APPLICATION LINK SENT WITH THE REPORT.

Comply By: 11/21/24

Type: Full
Date: 10/21/24
Time: 11:45:58
Report: 1037241253
Hyatt House Llc

Food and Beverage Establishment Inspection Report

Page 2

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

DISHWASHER APPEARS TO BE MALFUNCTIONING ON THE CHLORINE LINES OR PUMP. REPAIR TO MAINTAIN CHLORINE SOLUTION IN THE RINSE CYCLE AT 50-100 PPM.

Comply By: 10/28/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

UPRIGHT FREEZER IN THE KITCHEN WAS NOT OPERATIONAL. REMOVE BROKEN FREEZER FROM THE FACILITY OR REPAIR TO BE IN WORKING ORDER.

Comply By: 11/21/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

FIRE EXTINGUISHERS IN THE KITCHEN WERE LAST TAGGED FOR SERVICE IN JANUARY 2023 AND JANUARY 2021. SERVICE AND TAG ALL FIRE EXTINGUISHERS ANNUALLY.

Comply By: 11/21/24

6-300 Physical Facility Numbers and Capacities

6-303.11C

MN Rule 4626.1470C Provide at least 50 foot candles (540 LUX) of light intensity for areas where food employees are working with utensils and equipment where safety is a factor.

ORDER ORIGINALLY WRITTEN ON 8/17/21. 10/26/21: THERE ARE SEVERAL BULBS IN LIGHT FIXTURES THROUGHOUT THE KITCHEN THAT ARE BURNED OUT. REPLACE BULBS. 10/21/24 NO CHANGE. REPAIR LIGHT FIXTURES THROUGHOUT KITCHEN.

Comply By: 12/21/24

Surface and Equipment Sanitizers

Chlorine: = 10 at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK JUG
Violation Issued: No

Type: Full
Date: 10/21/24
Time: 11:45:58
Report: 1037241253
Hyatt House Llc

Food and Beverage Establishment Inspection Report

Page 3

Process/Item: Cooking

Temperature: 197 Degrees Fahrenheit - Location: GROUND BEEF AND NOODLE CASSEROLE

Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	1	5

DISCUSSED ORDERS, EMPLOYEE ILLNESS RECORDING, BARE HAND CONTACT, AND COOLING WITH KRISTY AND ANGIE WHILE ONSITE. COOLING FACT SHEET AND COOLING LOG LEFT ONSITE.

CFPM APPLICATION LINK:

<https://mn-mdh.portal.opengov.com/categories/1087/record-types/6498>

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1037241253 of 10/21/24.

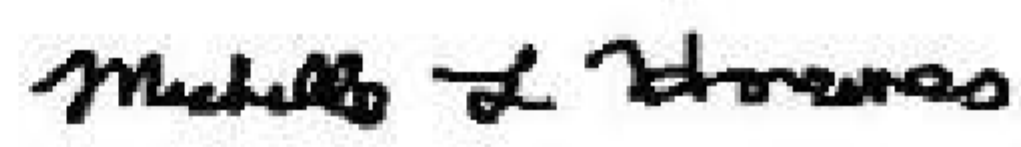
Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

ANGIE MILHAUSER

Signed:  _____

Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037241253		Food Establishment Inspection Report											
 Minnesota Department of Health Food, Pools, and Lodging PO Box 64975 St. Paul, MN 55164		No. of RF/PHI Categories Out				2		Date		10/21/24			
		No. of Repeat RF/PHI Categories Out				0		Time In		11:45:58			
		Legal Authority MN Rules Chapter 4626						Time Out					
Hyatt House Llc		Address 231 Washington Street			City/State Holdingford, MN			Zip Code 56340		Telephone 3207469902			
License/Permit # 0037490		Permit Holder			Purpose of Inspection Full			Est Type		Risk Category			
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS													
Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item													
Mark "X" in appropriate box for COS and/or R													
IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS=corrected on-site during inspection R= repeat violation													
Compliance Status						COS		R					
Supervision													
1		IN OUT		PIC knowledgeable; duties & oversight									
2		IN OUT N/A		Certified food protection manager, duties									
Employee Health													
3		IN OUT		Mgmt/Staff;knowledge,responsibilities&reporting									
4		IN OUT		Proper use of reporting, restriction & exclusion									
5		IN OUT		Procedures for responding to vomiting & diarrheal events									
Good Hygenic Practices													
6		IN OUT N/O		Proper eating, tasting, drinking, or tobacco use									
7		IN OUT N/O		No discharge from eyes, nose, & mouth									
Preventing Contamination by Hands													
8		IN OUT N/O		Hands clean & properly washed									
9		IN OUT N/A N/O		No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed									
10		IN OUT		Adequate handwashing sinks supplied/accessible									
Approved Source													
11		IN OUT		Food obtained from approved source									
12		IN OUT N/A N/O		Food received at proper temperature									
13		IN OUT		Food in good condition, safe, & unadulterated									
14		IN OUT N/A N/O		Required records available; shellstock tags, parasite destruction									
Protection from Contamination													
15		IN OUT N/A N/O		Food separated and protected									
16		IN OUT N/A		Food contact surfaces: cleaned & sanitized									
17		IN OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food									
GOOD RETAIL PRACTICES													
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.													
Mark "X" in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R= repeat violation													
						COS		R					
Safe Food and Water													
30		IN OUT N/A		Pasteurized eggs used where required									
31				Water & ice obtained from an approved source									
32		IN OUT N/A		Variance obtained for specialized processing methods									
Food Temperature Control													
33				Proper cooling methods used; adequate equipment for temperature control									
34		IN OUT N/A N/O		Plant food properly cooked for hot holding									
35		IN OUT N/A N/O		Approved thawing methods used									
36				Thermometers provided & accurate									
Food Identification													
37				Food properly labeled; original container									
Prevention of Food Contamination													
38				Insects, rodents, & animals not present									
39				Contamination prevented during food prep, storage & display									
40				Personal cleanliness									
41				Wiping cloths: properly used & stored									
42				Washing fruits & vegetables									
Risk factors (RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.													
						COS		R					
Proper Use of Utensils													
43				In-use utensils: properly stored									
44				Utensils, equipment & linens: properly stored, dried, & handled									
45				Single-use/single service articles: properly stored & used									
46				Gloves used properly									
Utensil Equipment and Vending													
47		X		Food & non-food contact surfaces cleanable, properly designed, constructed, & used									
48		X		Warewashing facilities: installed, maintained, & used; test strips									
49				Non-food contact surfaces clean									
Physical Facilities													
50				Hot & cold water available; adequate pressure									
51				Plumbing installed; proper backflow devices									
52				Sewage & waste water properly disposed									
53				Toilet facilities: properly constructed, supplied, & cleaned									
54				Garbage & refuse properly disposed; facilities maintained									
55				Physical facilities installed, maintained, & clean									
56		X		Adequate ventilation & lighting; designated areas used									
57				Compliance with MCIAA									
58				Compliance with licensing & plan review									
Food Recalls:													
Person in Charge (Signature)													
Date: 10/21/24													
Inspector (Signature)						