Electronically Delivered

July 7, 2023

Licensee
Cedars of Austin
700 1st Drive Northwest
Austin, MN 55912

RE: Project Number(s) SL30438015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 8, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH concludes the licensee is in substantial compliance. 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.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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 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).

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

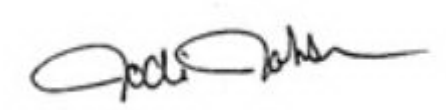
Please address your cover letter for reconsideration requests to:

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

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 me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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 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: SL30438015 On June 5, 2023, through June 8, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 117 active residents; 93 receiving services under the Assisted Living with Dementia Care license. 2070: An immediate correction order was identified on June 8, 2023. The immediacy was removed; however, non-compliance remains at a level 2, widespread scope (F).	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=E	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a means for residents in the facilities four secured memory care floors to request assistance for health and safety needs 24 hours a day, seven days a week for three of four residents (R5, R2, R1). This had the potential to affect all secured unit residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 460	Continued From page 2 The findings include: The licensee held an Assisted Living with Dementia Care License with a bed capacity of 145, census was 103, with 26 of those residents residing on one of the four secured memory care units. The physical layout of the facility consisted of non-secured apartments (Millpond) and four secured memory care floors (Landmark). During the entrance conference on June 5, 2023, at 10:48 a.m. licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS) stated the licensee had a system in place for residents to call for assistance for health and safety needs 24 hours a day, 7 days a week. R5 R5's diagnoses included schizophrenia (mental disorder), cognitive deficits, diabetes, and chronic obstructive pulmonary disease (COPD) (breathing difficulty). R5's Service Plan - Private dated March 10, 2023, indicated R5 received services which included medication administration, morning cares, evening cares, bathing assist, laundry, and housekeeping. R5's Admission Assessment dated March 10, 2023, and Clinical Update Assessment dated March 24, 2023, identified R5 was able to complete a return demonstration of how to activate the pendant emergency call system, but was unable to explain when to use the pendant emergency call system. Both assessments indicated, based on the two questions, R5 would not be given an emergency pendant. In addition, R5's Clinical Updated Assessment dated March 24, 2023, included a Brief Interview for Mental	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 460	Continued From page 3 Status (BIMS) score of 13 which identified R5 was cognitively intact. An Incident Report dated March 11, 2023, at 12:30 p.m. identified R5 fell on the floor by his apartment in the hallway outside his room. R5's Incident Report included another male resident found him lying on the floor and informed staff. On June 6, 2023, at 7:35 a.m. unlicensed personnel (ULP)-C stated only one resident on the third-floor secured unit had a call pendant. ULP-C indicated hourly checks of all residents were performed but were not documented. On June 6, 2023, at 7:51 a.m. the surveyor observed ULP-C administer medications to R5. On June 6, 2023, at 12:58 p.m. R5's room was observed. There was no call light in R5's room or bathroom. R5 was not wearing a call pendant. R5 stated he would have to "get up and get someone to come help me" or "yell" if he needed help. R2 R2's diagnoses included dementia (memory problem), diabetes (high blood sugar), bilateral edema (fluid retention) of lower extremities, and osteoarthritis (joint pain and stiffness). R2's Service Plan (Waiver)- Addendum to Contract dated February 27, 2023, indicated R2 received services which included medication administration, bathing assist, blood glucose monitoring, TED (thrombo-embolic deterrent) stockings (compression socks used to increase circulation and reduce swelling in the legs), housekeeping, and laundry.	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 460	Continued From page 4 On June 6, 2023, at 8:40 a.m. the surveyor observed ULP-D obtain R2's blood sugar and administer medications. R2's Admission Assessment dated February 27, 2023, and 14-day assessment dated March 14, 2023, identified R2 was not able to complete a return demonstration of how to activate the pendant emergency call system, or able to explain when to use the pendant emergency call system. Both assessments indicated, based on the two questions, R2 would not be given an emergency pendant. On June 6, 2023, at 12:22 p.m. R2's room was observed. There was no call light in R2's room or bathroom. R2 was not wearing a call pendant. R2 stated she would have to "go get someone" or "scream" if she needed help. On June 6, 2023, at 12:40 p.m. ULP-D stated only two residents on the fourth-floor secured unit had call pendants. ULP-D indicated he did rounds every 15 minutes to check on residents, but ULP-D did not document that anywhere. R1 R1's diagnosis included dementia. R1's Service Plan - Private dated August 1, 2021, indicated R1 received services which included medication administration, morning cares, evening cares, toileting assist, transfer assist, meal assist, bathing assist, Ace wraps, laundry, and housekeeping. R1's Clinical Update assessments dated January 11, 2023, and May 5, 2023, identified R1 was not able to complete a return demonstration of how to activate the pendant emergency call system, or	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 460	Continued From page 5 able to explain when to use the pendant emergency call system. Both assessments indicted, based on the two questions, R1 would not be given an emergency pendant. On June 5, 2023, at 1:17 p.m. R1's room was observed. There was no call light in R1's room or bathroom. R1 was not observed wearing a call pendant. ULP-J stated R1 did not wear a call pendant. On June 6, 2023, at 7:17 a.m. R1 was observed sitting in a wheelchair at dining room table eating independently. On June 8, 2023, at 10:17 a.m. CNS-B stated if residents residing in the secured unit did not know how or when to use the call pendant, a call pendant would not be issued to the resident. CNS-B stated most residents residing in the secured unit did not have a call pendant and there were no call cords within the individual rooms. CNS-B stated all residents should have a way to request assistance. The licensee's System for Residents to Summon Staff Assistance & System to Check on Residents Daily policy dated August 1, 2021, indicated the agency would maintain a system for all residents to summon staff assistance and a system to check on all residents at least daily. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 510 SS=E	144G.41 Subd. 3 Infection control program	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 510	Continued From page 6 (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 effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during AM cares and catheter care for one of one resident (R3), and for three of six residents (R9, R7, R2) during medication administration. 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: R3	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 510	Continued From page 7 R3's Service Plan - Private dated April 7, 2022, indicated R3 received services which included medication administration, morning cares, evening cares, bathing assist, catheter care, blood glucose monitoring, laundry, and housekeeping. On August 6, 2023, at 8:16 a.m. unlicensed personnel (ULP)-E and ULP-F were observed assisting R3 with morning cares; this included applying ace wraps to the resident's lower legs and performing catheter care. R3 was seated in her wheelchair; ULP-E and ULP-F donned gloves, applied a gait belt around R3's waist, and assisted her with standing so they could remove her pajama pants. R3's large urinary drainage bag was observed lying on the floor next to her wheelchair. Once the ULP had lowered the resident's pants, they then lowered R3 back into her wheelchair and removed the gait belt. ULP-F assisted R3 with removing her pajama top, applied lotion to the resident's back, then assisted R3 with putting on her top. ULP-E proceeded to remove R3's pajama pants, weaving the urinary drainage bag through the leg opening and once removed, placed the drainage bag back on the floor. ULP-E then applied ace wraps to the resident's lower legs and assisted with putting on a clean pair of pants. ULP-E weaved the resident's catheter drainage bag through the left pant leg then laid it on the floor. ULP-E and ULP-F then applied a gait belt around the resident's waist, assisted her with standing, pulled up the resident's pants, then assisted her back into her wheelchair. ULP-F removed her gloves, cleansed hands with hand sanitizer and exited the room. ULP-E then hung R3's urinary drainage bag under her wheelchair, removed her gloves, and moved the resident into the bathroom. ULP-E did not cleanse her hands after removing	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 510	Continued From page 8 gloves. Once in the bathroom, ULP-E donned clean gloves, and assisted the resident with standing while R3 hung onto the assist bar by the toilet. ULP-E lowered R3's pants then assisted the resident with sitting back down in her wheelchair. ULP-E then cleansed within the folds of resident's abdominal panniculus (stomach overhang), dried the area, then applied Z-guard paste, and inserted two rolled up washcloths into the overhang space to absorb moisture. ULP-E then assisted R3 with standing again, changed the resident's incontinence product and provided pericare. ULP-E then pulled up the resident's pants and assisted with sitting back down in the wheelchair. ULP-E then removed her gloves, did not cleanse her hands, and moved the resident closer to the bathroom sink so the resident could complete her morning routine. ULP-E then donned clean gloves and stated she was going to empty R3's catheter bag. ULP-E obtained a urinal, disconnected the drainage tube from the catheter bag port and drained the urine into the urinal. ULP-E then reattached the drainage tube into the port without cleansing the end of the tube with an alcohol wipe. ULP-E measured the urine then emptied into the toilet, rinsed the urinal from the tub faucet and again emptied into the toilet. ULP-E then doffed her gloves and went into the resident's bedroom to make the bed. The surveyor asked ULP-E when she would wash her hands, she stated, "When I'm all done". ULP-E then stated she should have cleansed her hands "in between" but didn't. On June 6, 2023, at 1:15 p.m. clinical nurse supervisor (CNS)-B stated the expectation with glove removal would be to cleanse hands after removing gloves and prior to applying clean gloves. CNS-B further stated she would expect	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 510	Continued From page 9 end of catheter drainage bag tube to be cleansed with alcohol after draining urine and not to let the drainage bag touch the floor. CNS-B stated these were infection control issues. On June 6, 2023, at 7:20 a.m. the surveyor observed ULP-C perform a blood glucose check on R9 in his room. Without washing or sanitizing their hands, ULP-C donned clean gloves, wiped R9's finger with an alcohol wipe, poked the finger with a lancet, wiped the blood off and then placed a sample of blood on the strip inserted in the glucometer. ULP-C then wiped the blood from R1's finger with a tissue, and with the same gloves still on, grabbed R9's Levimir (long acting) insulin pen from plastic container, administered the insulin, put the pen back into plastic container, opened R9's door, and carried the plastic container, lancet and used needle, back to the medication cart where lancet and needle were disposed of in a sharps container. Still wearing the same gloves, ULP-C grabbed the medication cart keys from her front pocket, unlocked the medication cart, opened a drawer, and put the plastic container away. ULP-C then took the paper medication administration record (MAR) book from the cart and placed it on top of the medication cart. ULP-C removed her gloves and disposed of them in the garbage. Without performing hand hygiene, ULP-C took her pen from her pocket and documented the tasks completed for R9, and then turned the pages of the paper MAR and went on to prepare medications for R7. ULP-C prepared all medications and brought the medication cup to the kitchen, reached into her pocket to unlock the 1/2 door using keys from her pocket, then opened the refrigerator door and obtained a pitcher and poured water from the pitcher into a cup. ULP-C placed the pitcher back into the refrigerator,	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 510	Continued From page 10	0 510		

closed the 1/2 door, and administered medications to R7 in his room.

On June 6, 2023, at 7:44 a.m. following administration of medications to R7, the surveyor questioned ULP-C regarding the lack of hand hygiene observed, ULP-C stated she "forgot" to wash or sanitize hands and should have, indicating she usually washed her hands before and after glove use and with each resident's medication administration.

On June 6, 2023, at 8:40 a.m. the surveyor observed ULP-D perform a blood glucose check on R2 in her room. Without washing or sanitizing hands, ULP-D donned clean gloves, wiped R2's finger with an alcohol wipe, poked the finger with a lancet, wiped the blood off and then placed a sample of blood on the strip inserted in the glucometer. With the same gloves still on, ULP-D administered R2's Humalog (fast acting) insulin, grabbed a pen from his front pocket and documented the medication and blood sugar results, picked up the paper MAR book and brought it back to medication cart, unlocked the medication cart using keys from his front pocket, and placed the book inside. ULP-D then removed his gloves, locked medication cart, walked over to kitchenette, unlocked 1/2 door, opened the refrigerator, poured a glass of juice, and grabbed a bowl of fruit from the counter. ULP-D then carried the items and placed in front of R2 all without performing hand hygiene.

On June 6, 2023, at 8:56 a.m. after ULP-D served R2 her breakfast, the surveyor questioned ULP-D regarding the lack of hand hygiene observed. ULP-D stated "will do that now" and stated he should have washed his hands after giving the medications and with glove use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 510	Continued From page 11 On June 8, 2023, at 10:40 a.m. CNS-B stated hand hygiene should have been performed before and after glove use and between medications. CNS-B stated a hand washing skills fair had just been held for staff. The licensee's Hand Washing/Sanitizing policy dated August 1, 2021, noted hands should be washed or sanitized before and after direct contact with a client, after contact with environmental surfaces or equipment in the immediate vicinity of the client, and after removing gloves. The licensee's Procedure for Using Gloves policy dated August 1, 2021, included: APPLYING GLOVES 1. Perform hand hygiene REMOVING GLOVES 4. Perform hand hygiene No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by:	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 620	Continued From page 12 Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R5) who reported allegation of sexual abuse for R12. 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: R5's diagnoses included schizophrenia (mental disorder) and cognitive deficits. R5's Service Plan - Private dated March 10, 2023, indicated R5 received services which included medication administration, morning cares, evening cares, bathing assist, laundry, and housekeeping. R5's Individualized Abuse Prevention Plan (IAPP) dated March 24, 2023, indicated the resident had a memory problem and staff were to monitor for signs and symptoms of depression and anxiety. The IAPP further identified R5 had no behaviors that required intervention. R5's Clinical Updated Assessment dated March 24, 2023, included a Brief Interview for Mental Status (BIMS) score of 13 which identified R5 was cognitively intact.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 620	Continued From page 13 R5's Resident Notes dated June 4, 2023, at 8:46 a.m. indicated staff had called the on-call nurse day before and informed nurse R5 asked a male staff "is your wife mad at you for cheating on her?" "yeah, you raped another resident who is now deceased. She told me." The note further indicated the staff was unsure what R5 was talking about and the resident that had passed away was nonverbal. The noted further identified the nurse had advised to remove the male staff off that floor and have resident head back to his room. Nurse also instructed that if resident got violent to call 911. On June 6, 2023, at 12:58 p.m. R5 told the surveyor R12 used to be his neighbor but she had passed away three or four weeks ago. R5 stated prior to R12's passing, R12 told R5 "unlicensed personnel (ULP)-G had raped her, put his penis in her, and now she felt like a whore". R5 stated he had promised R12 before she passed away that he would take care of this. R5 further stated he confronted ULP-G approximately four days ago, but he denied it. R5 also included he told another unidentified male ULP on staff about the incident. On June 6, 2023, at 2:05 p.m. licensed assisted living director (LALD)-A was informed what R5 had told surveyor. LALD-A further stated she was not aware of this incident until at this time. On June 7, 2023, 3:20 p.m. clinical nurse supervisor (CNS)-B stated LALD-A had spoken to her about the allegation R5 made regarding R12 and ULP-G. CNS-B stated a MAARC report had not been filed. CNS-B indicated she would have reported it if she thought it was valid. CNS-B stated R5 had said something similar last weekend and indicated R5 makes sexually	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 620	Continued From page 14 related delusional statements. The surveyor instructed CNS-B to report to MAARC immediately, which CNS-B stated she would and then start an investigation. The licensee's Vulnerable Adult Reporting and Investigation Policy dated August 1, 2021, indicated: 3. Internal Reporting Process Any staff person who witnesses or suspects any form of client maltreatment must report the incident immediately to the Executive Director, Director of Healthcare, registered nurse/licensed practical nurse (RN/LPN) in charge or their supervisor/department head, who will then report to the Director of Healthcare or Executive Director. 4. Immediate Report to MAARC Required Upon hearing the witness' description of the incident, if the incident appears to be suspected abuse, neglect, or financial exploitation, the Director of Healthcare or Executive Director or designated RN/LPN shall immediately make a report to MAARC. "Immediately" means as soon as possible, but no longer than 24 hours from the time of initial knowledge that the incident has occurred. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=D	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	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 630	Continued From page 15 individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for one of five residents (R5). 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: R5's diagnoses included schizophrenia (mental disorder) and cognitive deficits. R5's Service Plan - Private dated March 10, 2023, indicated R5 received services which included medication administration, morning cares, evening cares, bathing assist, laundry, and housekeeping. R5's Individual Abuse Prevention Plan (IAPP) dated March 24, 2023, noted activity of daily living	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 630	Continued From page 16 needs, independent living, medications, physical, safety, social, cognitive, and fall risk areas of vulnerability with statement of specific measures to be taken to minimize the risk. However, the assessment lacked an individualized review or assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On June 8, 2023, at 10:17 a.m. clinical nurse supervisor (CNS)-B stated the required components were lacking from R5's assessment. CNS-B indicated the nurse had not check marked the boxes on the assessment for the required components. CNS-B stated they may need to look at updating their electronic version to ensure the checkboxes must be addressed before advancing the assessment. The licensee's Vulnerable Adult Reporting and Investigation Policy dated August 1, 2021, lacked the development and implementation of an individual abuse prevention plan for each vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 650	Continued From page 17 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 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 interview and record review, the licensee failed to ensure two of two unlicensed personnel's (ULP-E, ULP-D) records included an annual performance review as required. 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:	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 650	Continued From page 18 ULP-E ULP-E began providing direct care services for the licensee on October 12, 2021. ULP-E's record lacked evidence of the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs. On June 8, 2023, at 10:44 a.m. licensed assisted living director (LALD)-A confirmed ULP-E's employee record did not include evidence an annual performance review had been completed since hire. ULP-D ULP-D started employment on November 16, 2021. ULP-D's record lacked evidence of the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs. On June 8, 2023, at 11:55 a.m. LALD-A stated she was unable to locate a performance review for ULP-D. LALD-A indicated previously someone else was completing/tracking when due and now she had some "catching up to do" for performance evaluations of the staff. The licensee's Performance Review policy dated August 1, 2021, indicated each supervisor/department head would complete an annual performance review for each employee they supervise on or before the employee's anniversary date.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 650	Continued From page 19 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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 by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 20 content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan last reviewed October 6, 2022, included a hazard and vulnerability assessment, and various policies/procedures. However, the plan lacked the following required content: -Development of all policies/procedures for: -Sewage and waste disposal; -Evacuation transportation; -Sharing information on occupancy/needs, and its ability to provide assistance. - Emergency prep testing requirements On June 8, 2023, at 1:09 p.m. licensed assisted living director (LALD)-A confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z to include the above requirements. LALD-A indicated she was not aware of all the emergency preparedness requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 690	Continued From page 21	0 690		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain records for two of five residents (R5, R1) for whom they provided services included authentication of documentation for staff, with the name and title of the person making the entry. 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: R5 R5's Service Plan - Private dated March 10, 2023, indicated R5 received services which included medication administration, morning cares, evening cares, bathing assist, laundry, and housekeeping. On June 6, 2023, at 7:51 a.m. unlicensed personnel (ULP)-C was observed to administer	0 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 690	Continued From page 22 medications to R5. R5's Medication Administration Record (MAR) dated May 2023, and June 1-6, 2023, and corresponding Service Chart documents were reviewed. Both forms had a page for staff to write in their name, title, and initials. ULP-C had initials on R5's MAR and Service Chart document dated May 2, 3, 8, 9, 13, 14, 15, 22, 23, 24, 30, and 31, 2023, and June 6, 2023. ULP-C was not identified by name, initials, or title on either of R5's May or June's MAR or Service Chart documents. R1 R1's Service Plan - Private dated August 1, 2021, indicated R1 received services which included medication administration, morning cares, evening cares, toileting assist, transfer assist, meal assist, bathing assist, Ace wraps, laundry, and housekeeping. On June 6, 2023, at 7:13 a.m. ULP-K stated she had completed cares and administered all morning medications and treatments to R1. R1's MAR and corresponding Service Chart documents dated June 1-6, 2023, were reviewed. Both forms had a page for staff to write in their name, title, and initials. ULP-K had initials on R1's MAR and Service Chart document dated June 1, 3, 4, and 6, 2023. ULP-K was not identified by name, initials, or title on either of R1's June MAR or Service Chart documents. On June 7, 2023, at 11:12 a.m. ULP-E stated if you do cares or medications for a resident, you must sign the signature sheet to identify name, initials, and title.	0 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 690	Continued From page 23 On June 8, 2023, at 10:28 a.m. clinical nurse supervisor (CNS)-B stated each caregiver currently needs to sign their name with title and initials monthly on each resident's MAR and/or Service Chart document. CNS-B stated resident records containing staff initials should be authenticated with name and title. The licensee's Content of Client Records policy dated August 2021, indicated: Record entries will be legible, permanently recorded, dated, and signed by the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 24 (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 interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 25 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: R6's record lacked a discharge summary to include: - diagnoses; - courses of illnesses; - allergies; - treatments and therapies; - 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, behavioral, and functional status. R6 was admitted to the licensee on December 16, 2021, with diagnoses including Alzheimer's dementia. R6 discharged from the facility on March 2, 2023. R6's Service Plan dated June 4, 2022, indicated the resident received services including morning and evening cares, medication administration, bathing and toileting assistance, housekeeping, laundry, and reassurance checks. R6's record/progress notes did not include information related to discharge. On June 8, 2023, at 11:34 a.m. clinical nurse supervisor (CNS)-B provided the surveyor with a discharge summary for R6 dated June 6, 2023. CNS-B confirmed she had not completed the	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 26 discharge summary until after the surveyor entered the facility and requested it. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 780	Continued From page 27 Based on observation and interview, the licensee failed to provide the required smoke alarms in all resident bedrooms, maintained smoke alarms, and interconnection of smoke alarms inside the one-bedroom and two-bedroom resident apartment units throughout the facility. This has the potential to directly affect all residents receiving services, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 7, 2023, at approximately 10:40 a.m. to 12:50 p.m. and 1:25 p.m. to 3:45 p.m., survey staff toured the facility with the director of maintenance (DM)-H and the licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: - Inside the one-bedroom and two-bedroom resident units throughout the facility, the smoke alarms inside the resident units were not interconnected when tested by the DM-H by activating the smoke alarms and each smoke alarm sounded local. -No smoke alarms were provided inside the resident bedrooms 206b and 308a, 131, 253, 320, 353, 358, 362, 357, and 361. -Inside resident room 205b, the smoke alarm (squared shape) located in the hallway failed to sound when the DM-H tested the smoke alarm. - The smoke alarms were not maintained as	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 780	Continued From page 28 required to ensure smoke alarms did not exceed 10 years from the date of manufacture. Survey staff observed that the label on the back of the smoke alarms had a manufactured date stamp, 10/2011 (resident rooms 308a and 353). The LALD-A and the DM-H physically and/or verbally verified the above findings accompanying the tour. On June 7, 2023, at approximately 4:30 p.m., during the exit interview, the LALD-A and the DM-H acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 800	Continued From page 29 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 7, 2023, at approximately 10:40 a.m. to 12:50 p.m. and 1:25 p.m. to 3:45 pm, survey staff toured the facility with the director of maintenance (DM)-H and the licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: - The 1st-floor south and 3rd-floor (middle) stairway fire-rated doors failed to positively latch when closed to protect the fire-rated integrity of the stairway for exiting. - The 4th-floor laundry room and the 2nd-floor fire-rated storage doors failed to latch when closed to protect and maintain the smoke-tight integrity of the corridor. - The fire-rated doors including the elevator lobby fire-rated door (near the courtyard) on the lower-level floor were wedged in the open position comprising the fire/smoke integrity of the corridor. The elevator lobby fire-rated door hardware had been removed and comprised. -The ground (or lower-level) floor maintenance room fire-rated door failed to positively latch when closed. -Inside the culinary office (lower-level floor), the sink and urinal fixtures and related plumbing were abandoned with plumbing traps completely dried out during the tour. Survey staff explained to the	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 800	Continued From page 30 DM-H that dried-out plumbing traps create unsafe and health risks to residents and employees over time by allowing sewer gas to enter the building environment and must be maintained regularly or removed and capped off properly. -In the lower-level mechanical room (boilers/water heaters), the water softener backwash discharge line was submerged into the sanitary sewage sump which poses potential cross-connection and contamination water softener system (building drinking water). The backwash line must discharge to an approved receptor (floor drain/standpipe) through a proper air gap. -Inside the 3rd-floor stairway, two wall penetrations (approximately 5 inches by 3 inches in size) had not been patched. The LALD-A and the DM-H physically and/or verbally verified the above findings accompanying the tour. On June 7, 2023, at approximately 4:30 p.m., during the exit interview, the LALD-A and the DM-H acknowledged the above findings. Additional information was provided by the LALD-A and received Thursday 6/8/2023 at 2:15 p.m. on the annual fire suppression test and inspection dated 1/12/2023, and the fire alarm inspection and testing dated 1/12/2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 31 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the complete content of the fire safety and evacuation plan and the minimum frequency of employee training on fire safety and evacuation. This has the potential to directly affect the safety of all	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 32 residents receiving services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 7, 2023, at approximately 3:45 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-A. At approximately 4:20 p.m., document review and interview with the LALD-A and the director of maintenance (DM)-H indicated the following: - Documentation review showed the licensee lacked employee training specifically on the fire safety and evacuation plan for the facility twice a year after new hire orientation training. The records for new hire employee orientation through Educare emergency preparedness training were available for review but no records for the required fire safety training and evacuation training if twice a year after the orientation. The LALD-A verified the finding. -Documentation review indicated the licensee lacked procedures necessary for addressing resident movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. Unique resident needs during emergency movement or an evacuation may be residents who have mobility	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 33 limitations, cognitive impairment, visual/hearing impairment, or any residents needing assistance during an evacuation that must be addressed in the fire safety and evacuation plan documentation. During the interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. On June 7, 2023, at approximately 4:30 p.m., during the exit interview, the LALD-A and the DM-H acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	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 licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 970	Continued From page 34 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's assisted living contract included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. -Page 21, section 27 of the contract indicated: "Provider is not responsible for any loss, damage or injury that is done to Resident's property (including personal effects and medical equipment such as walkers, canes, dentures and hearing aids) in the Apartment of Community caused by fire, water, explosion or any other cause other than by proven willful misconduct by Provider's employees. Provider strongly suggests that Resident obtain renter's insurance to insure their property. Some medical equipment can be very expensive, Provider strongly suggest Resident talk to their insurance provider to make sure that the items Resident wants covered (such as hearing aids) are actually covered under their policy. some manufacturers of medical equipment may offer their own insurance or replacement policies. Provider encourages Resident to talk to the manufacturer of their medical equipment or their medical provider about these policies. Provider is not responsible for any damage or injury that is done to Resident or Resident's guests in the Apartment or Community caused by fire, water, explosion or any other cause other than by proven willful misconduct or proven failure to provide the	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 970	Continued From page 35 required standard of care by Provider's employees. Nothing in this provision shall be construed as imposing a lesser standard of care or responsibility than is required by law on Provider." On June 8, 2023, at 8:35 a.m. licensed assisted living director (LALD)-A stated the licensee's contract included the above content, and further stated the same contract was utilized for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01440	Continued From page 36 performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one unlicensed personnel (ULP)-E with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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-E was hired on October 12, 2021, to provide direct care services to residents of the facility. On June 6, 2023, at 7:27 a.m. ULP-E was observed applying ace wraps to R3's legs and also providing catheter care. ULP-C's employee record lacked documentation of a RN supervising ULP-C performing a delegated task within 30 days of beginning work with the licensee. On June 8, 2023, at 10:44 a.m. licensed assisted living director (LALD)-A stated ULP-E's 30-day	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01440	Continued From page 37 supervision of delegated tasks had not been completed as required. The licensee's Supervision of Licensed and Unlicensed Personnel dated August 1, 2021, indicated: 1. Supervision of Unlicensed Staff Performing Nursing or Delegated Nursing, Delegated Treatment or Assigned Therapy Services. a. Direct Supervision of Staff Providing Delegated Tasks. Direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatment or assigned therapy tasks must be performed within 30 days after the person has successfully completed orientation, has been trained and determined competent to perform all the tasks assigned and begun providing services unsupervised. The RN (registered nurse) or LPN (licensed practical nurse) designated by RN will directly supervised staff performing delegated nursing tasks. After the initial 30 day supervision, the RN will determine the frequency of ongoing, additional direct supervision based on the individual staff person's performance and on the needs and condition of individual clients, the types of services being provided and the experience of the staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=D	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	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01500	Continued From page 38 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 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:	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01500	Continued From page 39 (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 interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of four employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on November 16, 2021, to provide direct care services under the licensee's assisted living with dementia care license. ULP-D's employee record lacked evidence the employee had successfully completed annual	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01500	Continued From page 40 training as required, to include the following: -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On June 8, 2023, at 3:30 p.m. clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-A stated this component should have been on ULP-D's transcript under Guide to AL MN, as this was assigned each year. The licensee's undated Compliance Checklist for New Home Care Employees policy lacked information on annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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 41 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for two of five residents (R3, R1), failed to conduct a follow-up assessment with 14 days of admission for one of two residents (R2), and failed to conduct a change of condition assessment following hospitalization for one of two residents (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: R3 R3's Service Plan - Private dated April 7, 2022, indicated R3 received services which included medication administration, morning and evening	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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 42 cares, bathing assist, catheter care, blood glucose monitoring, laundry, and housekeeping. R3's last three assessments were requested. Assessments dated November 23, 2022, March 2, 2023, and May 17, 2023, were provided. 99 days had passed between the November and March assessments. On June 8, 2023, at 11:34 a.m. clinical nurse supervisor (CNS)-B confirmed R3's March 2, 2023, assessment had not been completed within 90 days as required. R1 R1's Service Plan - Private dated August 1, 2021, indicated R1 received services which included medication administration, morning cares, evening cares, toileting assist, transfer assist, meal assist, bathing assist, Ace wraps, laundry, and housekeeping. R1's last three assessments were requested. Assessments dated October 12, 2022, January 11, 2023, and May 5, 2023, were provided. The January 11, 2023, assessment was 91 days from the last date of the assessment, exceeding 90 calendar days. In addition, the May 5, 2023, assessment was 114 days from the last date of the assessment, exceeding 90 calendar days. R2 R2's Service Plan (Waiver)- Addendum to Contract dated February 27, 2023, indicated R2 received services which included medication administration, bathing assist, blood glucose monitoring, TED (thrombo-embolic deterrent) stockings (compression socks used to increase circulation and reduce swelling in the legs), housekeeping, and laundry.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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 43 R2's last two assessments were requested. An admission assessment dated February 27, 2023, and a 14-day assessment dated March 14, 2023, were provided. The March 14, 2023, assessment was 15 days from the date of the previous assessment, exceeding 14 calendar days. On June 8, 2023, at 10:42 a.m. CNS-B stated R1's assessments were greater than 90 days apart. CNS-B further stated R2's 14-day assessment was 1 day late. CNS-B stated she was aware there were some late assessments due to being down one RN to assist in completing the assessments timely. CNS-B stated she was working on hiring a new nurse. R4 R4's Service Plan - Private dated April 19, 2023, indicated R4 received service which included morning and evening cares, medication administration oxygen maintenance, bathing, housekeeping, and laundry. R4's progress note dated April 19, 2023, indicated the resident had returned from the hospital after a three day stay for complaints of a headache. While there she was found to be hypoxic (low amounts of oxygen in the blood) and needed oxygen continuously. She also had a fall in the hospital with no injury. R4's record did not include a change of condition assessment by the RN upon return from the hospital. On June 8, 2023, at 11:34 a.m. CNS-B confirmed a change of condition assessment had not been completed upon R4's return from the hospital on April 19, 2023.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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 44 The licensee's Initial and On-going Nursing Assessment of Clients policy dated August 1, 2021, noted a registered nurse (RN) would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required. b. 14-day assessment completed up to 14 days after start of services; c. Ongoing assessment completed periodically but no less than every 90-days; d. Change in resident condition No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by two of two	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01750	Continued From page 45 unlicensed personnel (ULP-F and ULP-D) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3's Service Plan - Private dated April 7, 2022, indicated services included medication administration and blood glucose monitoring. R3's Physician Orders dated July 25, 2022, included Novolin N (intermediate acting insulin) Flexpen 100 units/milliliter (ml), inject 16 units subcutaneously (under the skin) every morning. R3's Physician orders also included Novolog (fast-acting insulin) Flexpen 100 units/ml, inject 3 units subcutaneously three times daily with meal(s) plus per sliding scale. Inject as per sliding scale: if 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400 units=5 units, 401-450=6 units, if above 450, call provider. On June 6, 2023, at 8:55 a.m. ULP-F was observed administering insulin to R3. ULP-F obtained R3's Novolin N Flexpen, removed the cap, and proceeded to apply a new needle. ULP-F did not cleanse the end of the insulin pen with an alcohol wipe prior to applying the needle.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01750	Continued From page 46	01750		

ULP-F then primed the insulin pen by dialing it to two units and wasting the two units of insulin, then dialed the pen to 16 units. ULP-F used an alcohol wipe to R3's skin and administered the insulin in the resident's lower abdomen. ULP-F then repeated the same process with R3's Novolog Flexpen and again, did not cleanse the end of the pen with alcohol prior to applying the needle. ULP-F primed the insulin pen then dialed it to three units as the resident's blood sugar was less than 150 and did not require additional units. ULP-F used an alcohol wipe to R3's skin and administered the insulin in the resident's lower abdomen. Upon exiting R3's room, the surveyor asked ULP-F if she ever cleansed the end of the insulin pens with alcohol prior to applying a new needle. ULP-F stated she had not been trained to do that and further stated, "It makes sense".

R2
R2's Service Plan (Waiver)- Addendum to Contract dated February 27, 2023, indicated R2 received services which included medication administration and blood glucose monitoring.

R2's Physician Orders dated January 9, 2023, included Novolog (fast-acting insulin) Flexpen 100 units/milliliter (ml), 7 units subcutaneously three times per day plus sliding scale before every meal inject into abdomen. 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401 or higher give 12 units and call nurse.

On June 6, 2023, at 8:40 a.m. ULP-D was observed performing a blood sugar check for R2 in her room. Without washing or sanitizing hands, ULP-D donned clean gloves, wiped R2's finger with an alcohol wipe, poked the finger with a lancet, wiped the blood off and then placed a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01750	Continued From page 47	01750		

sample of blood on the strip inserted in the glucometer. ULP-D stated R2's blood sugar was 89 and would only be receiving the base amount of insulin. ULP-D obtained R2's Humalog Kwikpen, removed the cap, and proceeded to apply a new needle. ULP-D did not cleanse the end of the insulin pen prior to applying the needle. ULP-D then primed the insulin pen by dialing it to two units and wasting the two units of insulin, the dialed the pen to seven units. ULP-D used an alcohol wipe to R2's skin and administered the insulin in the resident's lower abdomen.

On June 6, 2023, at 9:50 a.m. ULP-D stated he did not use an alcohol wipe to cleanse the insulin pen prior to applying the needle. ULP-D stated he was not aware of this step and had been trained by the registered nurse (RN).

On June 7, 2023, at 11:17 a.m. ULP-I was observed to obtain R2's Humalog Kwikpen, removed the cap, and proceeded to apply a new needle. ULP-I did not cleanse the end of the insulin pen prior to applying the needle. ULP-I then primed the insulin pen by dialing it to two units, and wasting the two units of insulin, then dialed the pen to nine units (R2's blood sugar was 200) and administered the insulin to resident's abdomen. Immediately following the observation, ULP-I stated she had not cleansed the insulin pen prior to applying the needle. ULP-I stated she had never been trained to do that but indicated it made sense.

On June 6, 2023, at 1:15 p.m. clinical nurse supervisor (CNS)-B confirmed staff had not been trained to cleanse the end of insulin pens prior to attaching the needle.

The Humalog KwikPen instructions for use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01750	Continued From page 48 revised April 2020, included: Step 1: Pull the pen cap straight off, do not remove the pen label. Wipe the rubber seal with an alcohol swab. The licensee's undated, 02-204a.13 Cedars of Austin Skills/Competency Test - Insulin Administration - Pen form indicated: 8. Remove the pen cap and clean the rubber seal on the insulin cartridge with a sterile alcohol swab. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications had an opened date for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01890	Continued From page 49	01890		

limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R3's diagnoses included diabetes.

R3's Service Plan - Private dated April 7, 2022, indicated services included medication administration and blood glucose monitoring.

On June 6, 2023, at 8:55 a.m. unlicensed personnel (ULP)-F was observed setting up medication to administer for R3. While preparing R3's Novolin N FlexPen and Novolog FlexPen, the surveyor noted there was no date when opened on either pen. ULP-F confirmed the insulin pens were not dated when opened and should have been.

On June 6, 2023, at 1:15 p.m. clinical nurse supervisor (CNS)-B confirmed insulin needed to be dated when opened and would expect the ULP to contact the nurse if it hadn't been.

The licensee's undated, competency test form titled, Insulin Administration-Pen indicated: 6. Check appearance of the insulin and check RN instructions on consistency of clear or cloudy appearance, inspect insulin in pen to assure accuracy, viability and that expiration date has not passed. 7. Reference manufacturer's requirements and instructions as necessary.

The Novolin N FlexPen instructions for use revised November 2019, indicated: The Novolin N FlexPen you are using should be thrown away after 28 days, even if it still has insulin left in it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01890	Continued From page 50 The Novolog FlexPen instructions for use revised February 2023, indicated: The Novolog FlexPen you are using should be thrown away after 28 days, even if it still has insulin left in it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 51 the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R6). 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: During the entrance conference on June 5, 2023, at 10:48 a.m., clinical nurse supervisor (CNS)-B stated resident's medications were counted and documented upon discharge or if destroyed. R6 was admitted to the licensee on December 16, 2021, with diagnoses including Alzheimer's dementia. R6 discharged from the facility on March 2, 2023. R6's Service Plan dated June 4, 2022, indicated the resident received services including medication administration. R6's record did not include a reconciliation of medications upon discharge. On June 8, 2023, at 11:34 a.m. CNS-B confirmed being unable to find evidence R6's medications had been counted and reconciled upon discharge.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 52 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01960	Continued From page 53 The findings include: R2's diagnoses included dementia (memory problem), diabetes (high blood sugar), bilateral edema (fluid retention) of lower extremities, and osteoarthritis (joint pain and stiffness). R2's Service Plan (Waiver)- Addendum to Contract dated February 27, 2023, indicated R2 received services which included medication administration, bathing assist, blood glucose monitoring, TED (thrombo-embolic deterrent) stockings (compression socks used to increase circulation and reduce swelling in the legs), housekeeping, and laundry. On June 6, 2023, at 12:19 p.m. R2 was observed not wearing TED stockings. R2 stated she normally wore them all day and could put them on herself. R2 was unable to locate the TED stockings in her room at this time. On June 6, 2023, at 12:40 p.m. unlicensed personnel (ULP)-D stated R2 applied the TED stockings independently. ULP-D was not aware R2 was not wearing the TED stockings. On June 7, 2023, at 11:23 a.m. R2 was observed not wearing TED stockings. On June 7, 2023, at 11:29 a.m. ULP-I stated R2 applied TED stockings independently after cues each morning, then ULP-I stated "why? doesn't she have them on?" ULP-I observed R2 with the surveyor and further stated R2 was not wearing TED stockings. ULP-I indicated she would have to do more than cue R2 to apply them from now on. On June 7, 2023, at 3:15 p.m. ULP-M stated R2	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
01960	Continued From page 54 did not wear TEDS and only helped R2 with medications on the evening shift. R2's prescriber orders dated February 24, 2023, included an order to continue compression stockings. R2's recorded Service Chart document dated June 1, 2023, through June 7, 2023, included staff initials that TED stockings were applied during day and removed in evening. R2's evening services included to wash TEDS with mild soap, rinse well, towel dry and hang over shower rode to dry. R2's record lacked documentation of R2 declining the TED stockings or why the compression stockings had not been applied. On June 8, 2023, at 10:48 a.m. clinical nurse supervisor (CNS)-B stated staff should be checking to make sure R2 is wearing the TEDS and document cares provided and refusals. The licensee's Implementation of Medication Prescriptions and Treatment and Therapy Orders policy dated June 29, 2021, indicated the registered nurse (RN) and/or licensed health professional is responsible for assuring that the prescriptions and orders have been implemented appropriately through client monitoring, supervision of staff and review of client records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 55	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to develop complete content on the required memory care site-specific safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include:	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 56 On June 7, 2023, at approximately 10:40 a.m. to 12:50 p.m. and 1:25 p.m. to 3:45 pm, survey staff toured the facility with the director of maintenance (DM)-H and the licensed assisted living director (LALD)-A. On June 7, 2023, at approximately 3:45 p.m., survey staff received the safety risk assessment and mitigations documentation for review from the licensed assisted living director (LALD)-A. On June 7, 2023, at approximately 4:20 p.m., a documentation review and interview were performed with the licensed assisted living director (LALD)-A and the director of maintenance (DM)-H relating to the memory care safety risk/vulnerability assessment and mitigation plan, indicated the plan was incomplete and failed to identify memory care site-specific mitigations on the property to protect the memory care residents from harm. The finding was evident as the documentation provided for the review was an all-hazard community-based risk assessment (dated 8/29/2022) as part of an emergency preparedness plan documentation, Appendix Z, was provided for review but lacked mitigations. In addition, the document had a column " actions taken to mitigate" next to the hazard/vulnerabilities, but the column was not filled out with mitigations. The finding was confirmed during the interview with the DM-H, and the LALD-A that the licensee lacked the memory care site-specific mitigation provisions to protect the memory care residents from harm. On June 7, 2023, at approximately 4:30 p.m., during the exit interview, the LALD-A and the DM-H acknowledged the above findings. During the exit interview survey staff discussed the findings and explained that all potential memory care safety risks and/or vulnerabilities specific to	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 57 memory care residents on the memory care floors including access to stovetops/ovens, sharp objects, elopement risks including comprised resident windows, cleaning chemicals, small appliances, and any other risks need to be identified, assessed, and mitigated and be documented in the plan to protect the memory care residents from harm. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02070 SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the facility was staffed 24 hours a day, seven days a week in the locked memory care unit. This had the potential to affect all residents residing at the facility and resulted in an immediate correction order on June 8, 2023, at 11:52 a.m. 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	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
02070	Continued From page 58	02070		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

The facility was licensed as an assisted living facility with dementia care.

On June 5, 2023, at 10:48 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B identified there were five staff working during the night shift, one for each of the four secured memory care (MC) units, and one for the assisted living (AL). CNS-B stated as of now, there were no residents in the AL who required two-person assistance; CNS-B further stated if there was an emergency, a staff member from one of the four MC units would assist the staff in the AL

R11's incident reports for falls were reviewed and revealed the following:
- Falls on May 12, 2023, at 12:55 a.m. and 4:39 a.m. The first fall was witnessed, and the second fall he was found on the floor; he was trying to get himself to the bathroom both times. The resident was assisted off the floor with two staff and a gait belt. The on-call nurse was notified for each fall. The first call told staff to call MC for help to assist him up, monitor for injuries, and update nurse with status after standing up. Second call nurse told staff to get him off the floor, got vitals, and the nurse will assess him in the a.m.

R10's incident reports for falls were reviewed and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
02070	Continued From page 59 revealed the following: - Fall on June 1, 2023, at 3:00 a.m. Resident was found on her floor by her bed early this a.m., looking like she slid out of bed. Resident had no complaints of pain and didn't notice any injuries. Two staff and a gait belt assisted her off the floor. The daily staffing schedules dated May 12, 2023, and June 1, 2023, revealed only five staff were scheduled for the night shift. On June 8, 2023, at 11:34 a.m. CNS-B stated when there is a fall in the AL, staff were instructed to call MC staff to assist when needed, though this was infrequent. CNS-B further stated she, the licensed assisted living director (LALD), and the compliance officer were responsible for creating the staffing plan. On June 8, 2023, at 11:52 a.m. LALD-A stated if the AL staff needed emergent assistance, they would call staff from the MC unit for assistance. LALD-A further stated this would leave one of the MC units without a staff member present for a short time. The licensee's Staffing policy revised March 24, 2023, indicated: Staff will be available 24 hours per day to provide resident care and to respond to their scheduled and reasonably foreseeable unscheduled needs 24 hours per day, 7 days per week. A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonable foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan. No further information was provided.	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
02070	Continued From page 60 TIME PERIOD FOR CORRECTION: Immediate On June 8, 2023, the immediacy of correction order 2070 was removed; however, non-compliance remains at a scope and level of (F).	02070		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
02170	Continued From page 61	02170		

telling a life story, reminiscing, or playing music;
(5) spiritual, creative, and intellectual activities;
(6) sensory stimulation activities;
(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and
(8) outdoor activities.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation for four of four residents (R1, R2, R5, R3) who resided in the secured memory care units.

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

The findings include:

The licensee had an Assisted Living with Dementia Care (ALFDC) license effective August 1, 2022.

R1
R1's diagnosis included dementia.

R1's Service Plan - Private dated August 1, 2021, indicated R1 received services which included medication administration, morning cares, evening cares, toileting assist, transfer assist, meal assist, bathing assist, Ace wraps, laundry,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
02170	Continued From page 62 and housekeeping. R1's undated, Joining My Journey Program document included information on family history, overall personality, childhood and education, spirituality, connection with the military, hobbies, special interests, and everyday routine. However, it lacked an evaluation to include: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, the record lacked an individualized activity plan to include a selection of daily structured and non-structured activities. R2 R2's diagnoses included dementia. R2's Service Plan (Waiver)- Addendum to Contract dated February 27, 2023, indicated R2 received services which included medication administration, bathing assist, blood glucose monitoring, TED (thrombo-embolic deterrent) stockings (compression socks used to increase circulation and reduce swelling in the legs), housekeeping, and laundry. R2's undated, Joining My Journey Program document included information on family history, overall personality, childhood and education, spirituality, connection with the military, hobbies, special interests, and everyday routine. However, it lacked an evaluation to include: - current abilities and skills; - emotional and social needs and patterns;	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
02170	Continued From page 63 - physical abilities and limitations; - adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, the record lacked an individualized activity plan to include a selection of daily structured and non-structured activities. R5 R5's diagnoses included schizophrenia (mental disorder) and cognitive deficits. R5's Service Plan - Private dated March 10, 2023, indicated R5 received services which included medication administration, morning cares, evening cares, bathing assist, laundry, and housekeeping. R5's undated, Joining My Journey Program document included information on family history, overall personality, childhood and education, spirituality, connection with the military, hobbies, special interests, and everyday routine. However, it lacked an evaluation to include: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, the record lacked an individualized activity plan to include a selection of daily structured and non-structured activities. R3 R3's diagnoses included dementia.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
02170	Continued From page 64 R3's Service Plan - Private dated April 7, 2022, indicated R3 received services which included medication administration, morning cares, evening cares, bathing assist, catheter care, blood glucose monitoring, laundry, and housekeeping. R3's undated, Joining My Journey Program document included information on family history, overall personality, childhood and education, spirituality, connection with the military, hobbies, special interests, and everyday routine. However, it lacked an evaluation to include: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, the record lacked an individualized activity plan to include a selection of daily structured and non-structured activities. On June 8, 2023, at approximately 11:00 a.m. activity director (AD)-L stated the activity evaluations lacked the required content, and the records lacked an individualized activity plan for all residents. AD-L further stated she was aware of the requirement but had not implemented yet. The licensee's Description of Life Enrichment Programs and how Activities are Implemented in ALDC policy dated August 1, 2021, noted the lacking information on the activity evaluation or individualized activity plan. No further information was provided.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
02170	Continued From page 65 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02180 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure behavioral symptoms identified were addressed on the service plan for one of one resident (R5). 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	02180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
02180	Continued From page 66	02180		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2022.

R5's diagnoses included schizophrenia (mental disorder) and cognitive deficits.

R5's clinical update assessment dated March 24, 2023, identified staff were to monitor for signs and symptoms of depression and anxiety. The assessment further indicated the resident had no behaviors that required intervention.

R5's Individual Abuse Prevention Plan (IAPP) dated March 24, 2023, noted activity of daily living needs, independent living, medications, physical, safety, social, cognitive, and fall risk areas of vulnerability with statement of specific measures to be taken to minimize the risk. However, the assessment lacked an individualized review or assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.

An incident report dated May 2, 2023, at 6:00 p.m., indicated R5 hit another resident and told staff he was going to beat him up because "he was gay and wanted to have sex with him." R5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
02180	Continued From page 67	02180		

would not leave the other resident alone and was following him around and trying to go into his room.

An incident report dated May 14, 2023, at 3:30 p.m., indicated R5 threatened to punch another resident because he tried to get in his room. R5 stated he was going to leave door unlocked and if the resident opens it, he is going to knock him out.

R5's Resident Notes dated June 4, 2023, at 8:46 a.m. indicated staff had called the on-call nurse day before and informed nurse R5 asked a male staff "is your wife mad at you for cheating on her?" "yeah, you raped another resident who is now deceased. She told me." The note further indicated the staff was unsure what R5 was talking about and the resident that had passed away was nonverbal. The noted further identified the nurse had advised to remove the male staff off that floor and have resident head back to his room. Nurse also instructed that if resident got violent to call 911.

R5's Service Plan - Private dated March 10, 2023, included staff to monitor for signs and symptoms of depression and anxiety. However, R5's service plan did not identify the resident's verbal and physically aggressive behaviors.

On June 8, 2023, at 10:34 a.m. clinical nurse supervisor (CNS)-B stated R5's service plan lacked interventions to minimize the above behaviors for staff to implement. CNS-B stated depression was recognized but should have included his yelling, physical, and sexual allegations.

No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
02180	Continued From page 68 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02180		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
03000	Continued From page 69 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R5) who reported allegation of sexual abuse for R12. 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: R5's diagnoses included schizophrenia (mental disorder) and cognitive deficits.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
03000	Continued From page 70	03000		

R5's Service Plan - Private dated March 10, 2023, indicated R5 received services which included medication administration, morning cares, evening cares, bathing assist, laundry, and housekeeping.

R5's Individualized Abuse Prevention Plan (IAPP) dated March 24, 2023, indicated the resident had a memory problem and staff were to monitor for signs and symptoms of depression and anxiety. The IAPP further identified R5 had no behaviors that required intervention.

R5's Clinical Updated Assessment dated March 24, 2023, included a Brief Interview for Mental Status (BIMS) score of 13 which identified R5 was cognitively intact.

R5's Resident Notes dated June 4, 2023, at 8:46 a.m. indicated staff had called the on-call nurse day before and informed nurse R5 asked a male staff "is your wife mad at you for cheating on her?" "yeah, you raped another resident who is now deceased. She told me." The note further indicated the staff was unsure what R5 was talking about and the resident that had passed away was nonverbal. The noted further identified the nurse had advised to remove the male staff off that floor and have resident head back to his room. Nurse also instructed that if resident got violent to call 911.

On June 6, 2023, at 12:58 p.m. R5 told the surveyor R12 used to be his neighbor but she had passed away three or four weeks ago. R5 stated prior to R12's passing, R12 told R5 "unlicensed personnel (ULP)-G had raped her, put his penis in her, and now she felt like a whore". R5 stated he had promised R12 before she passed away that he would take care of this. R5 further stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
03000	Continued From page 71	03000		

he confronted ULP-G approximately four days ago, but he denied it. R5 also included he told another unidentified male ULP on staff about the incident.

On June 6, 2023, at 2:05 p.m. licensed assisted living director (LALD)-A was informed what R5 had told surveyor. LALD-A further stated she was not aware of this incident until at this time.

On June 7, 2023, 3:20 p.m. clinical nurse supervisor (CNS)-B stated LALD-A had spoken to her about the allegation R5 made regarding R12 and ULP-G. CNS-B stated a MAARC report had not been filed. CNS-B indicated she would have reported it if she thought it was valid. CNS-B stated R5 had said something similar last weekend and indicated R5 makes sexually related delusional statements. The surveyor instructed CNS-B to report to MAARC immediately, which CNS-B stated she would and then start an investigation.

The licensee's Vulnerable Adult Reporting and Investigation Policy dated August 1, 2021, indicated:
3. Internal Reporting Process
Any staff person who witnesses or suspects any form of client maltreatment must report the incident immediately to the Executive Director, Director of Healthcare, registered nurse/licensed practical nurse (RN/LPN) in charge or their supervisor/department head, who will then report to the Director of Healthcare or Executive Director.
4. Immediate Report to MAARC Required
Upon hearing the witness' description of the incident, if the incident appears to be suspected abuse, neglect, or financial exploitation, the Director of Healthcare or Executive Director or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
03000	Continued From page 72 designated RN/LPN shall immediately make a report to MAARC. "Immediately" means as soon as possible, but no longer than 24 hours from the time of initial knowledge that the incident has occurred. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *06/08/23*
Time: 09:14:52
Report: 1038231073

Food and Beverage Establishment Inspection Report

Location:
Cedars Of Austin
700 1st Drive Nw
Austin, MN55912
Mower County, 50

Establishment Info:
ID #: 0037750
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074373246
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 100ppm at Degrees Fahrenheit
Location: Chemical Dishwasher
Violation Issued: No

Chlorine: = at Degrees Fahrenheit
Location:
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: Veg. Soup
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -10 Degrees Fahrenheit - Location: Tater Tots
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -10 Degrees Fahrenheit - Location: Cake Roll
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 34 Degrees Fahrenheit - Location: Milk
Violation Issued: No

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

Type: Full
Date: *06/08/23*
Time: 09:14:52
Report: 1038231073
Cedars Of Austin

Food and Beverage Establishment Inspection Report

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

mbarajas@cedarsofaustin.com

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 1038231073 of 06/08/23.

Certified Food Protection Manager Bradley Ellis

Certification Number: FM103495 Expires: 06/10/23

Signed: _____
Establishment Representative

Signed: _____
Rob Davis
Public Health Sanitarian
Rochester District Office
rob.davis@state.mn.us