DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 6, 2022

Administrator
Hyatt House LLC
231 Washington Street
Holdingford, MN 56340

RE: Project Number(s) SL28686012

Dear Administrator:

On April 5, 2022, the Minnesota Department of Health completed a follow-up evaluation of your agency to determine correction of orders found on the evaluation completed on August 19, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the August 19, 2021 evaluation.

In accordance with Minn. Stat. § 144A.474, Subd. 11, state licensing orders issued pursuant to the last evaluation completed on August 19, 2021, found not corrected at the time of the April 5, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0340-Correction Orders-144g.30 Subd. 5 - $500.00

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00

The details of the violations noted at the time of this follow-up evaluation completed on April 5, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144A.43 to 144A.482, **the total amount you are assessed is $1,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144A.474, Subd. 8(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144A.475 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144A.475.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144A.474, Subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144A.474, Subd. 11(g) , a home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144A.475, Subd. 4 and Subd. 7, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917 .

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your agency's Governing Body.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28686	A. BUILDING: _____ B. WING _____	R 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYATT HOUSE LLC	231 WASHINGTON STREET HOLDINGFORD, MN 56340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28686012 On April 5, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 19, 2021, and revisit surveys completed on October 27, 2021, January 4, 2022, January 10, 2022, and March 2, 2022. At the time of the survey, there were 11 residents, all receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 340} SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	{0 340}		

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{0 340}	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on March 2, 2022, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	{0 340}		

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{0 340}	Continued From page 2 of the residents). The findings include: On April 5, 2022, at approximately 10:10 a.m., licensed assisted living director (LALD)-A stated she felt all corrections had been made. During the revisit survey on April 5, 2022, a review of the licensee's policies and procedures, employee records, and interviews with LALD-A lacked evidence to indicate the licensee corrected all orders issued on March 2, 2022. No further information was provided.	{0 340}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	{0 480}		

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{0 480}	Continued From page 3 No further information required.	{0 480}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written plan of action to facilitate the management of the resident's care and services in response to a natural disaster such as storms or other emergencies	{0 680}		

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{0 680}	Continued From page 4 that may disrupt the licensee's ability to provide care and services. In addition, the licensee failed to develop an all-hazards emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all 11 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 5, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-A provided the surveyor a copy of the Emergency Operations Plan, which was reviewed together and verified by LALD-A. The plan lacked the following required content: -identification of at-risk population needs including maintaining independence, communication, transportation, supervision and medical care; - qualified person authorized in writing to act in the absence of the administrator; and - communication plan to include: - the names and contact information for the residents' physicians; - State Licensing and Certification Agency; and - Minnesota Office of Ombudsman for Long-Term Care.	{0 680}		

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{0 680}	Continued From page 5 The licensee's Emergency Preparedness Plan dated January 1, 2021, indicated the agency would have a written plan of action in place to assure the safety and well-being of clients [residents] and staff during periods of an emergency or disaster that disrupts services. No further information was provided.	{0 680}		
{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}		

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{0 780}	Continued From page 6 No further information required.	{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: No further information required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	{0 810}		

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{0 810}	Continued From page 7 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further information required.	{0 810}		

Electronically Delivered

March 4, 2022

Administrator
Hyatt House LLC
231 Washington Street
Holdingford, MN 56340

RE: Project Number(s) SL28686012

Dear Administrator:

On March 2, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on August 19, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the August 19, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on August 19, 2021, found not corrected at the time of the March 2, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0340-Correction Orders-144g.30 Subd. 5 - $500.00
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 -
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917 .

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
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{0 340} SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	{0 340}		

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{0 340}	Continued From page 2 of the residents). The findings include: On March 2, 2022, at approximately 9:48 a.m., licensed assisted living director (LALD)-A stated she felt all corrections had been made. During the revisit survey on March 2, 2022, a review of the licensee's policies and procedures, employee records, and interviews with LALD-A and registered nurse (RN)-B lacked evidence to indicate the licensee corrected all orders issued on January 10, 2022. No further information was provided.	{0 340}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28686	A. BUILDING: _____ B. WING _____	R 03/02/2022

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{0 480}	Continued From page 3 by: No further information required.	{0 480}		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including completion of a two-step tuberculin skin test (TST) or other evidence of TB screening, such as a blood test, for one of two employees (unlicensed personnel (ULP)-N) with employee 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	{0 660}		

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{0 660}	Continued From page 4	{0 660}		

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

The findings include:

The licensee's Facility TB Risk Assessment dated March 19, 2021, identified a low risk level.

ULP-N was hired under the comprehensive home care license on July 22, 2021, and began providing assisted living services on August 1, 2021.

ULP-N's employee record lacked evidence of a two-step TST or other evidence of TB screening, such as a blood test.

On March 2, 2022, at approximately 9:48 a.m., licensed assisted living director (LALD)-A stated ULP-N had not done the blood test as requested and would be removed from the schedule until completed.

The licensee's TB Prevention and Control policy dated August 1, 2021, noted prior to contact with residents, staff would be screened for TB with a TST or single interferon gamma release assay blood test.

The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative

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{0 660}	Continued From page 5 IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients (residents). Baseline TB screening should be documented in the employee's record." No further information was provided.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	{0 680}		

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{0 680}	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written plan of action to facilitate the management of the resident's care and services in response to a natural disaster such as storms or other emergencies that may disrupt the licensee's ability to provide care and services. In addition, the licensee failed to develop an all-hazards emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all 10 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 2, 2022, at approximately 10:00 a.m., licensed assisted living director (LALD)-A provided the surveyor a copy of the Emergency Operations Plan after receiving it via email from the licensee's consultant. The plan included the following titled pages: - rapid response guide; - purpose of the plan; - bomb threat; - fire; - tornado/severe weather; - staffing during an emergency; and - emergency management summary.	{0 680}		

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{0 680}	Continued From page 7 On March 2, 2022, at approximately 10:40 a.m., the surveyor reviewed the plan with LALD-A and included via telephone registered nurse (RN)-B. Both staff indicated they had met with the consultant to review the requirements of the plan. In addition, they verified the plan lacked the required content of an emergency preparedness and Appendix Z plan to manage the residents' care and services in response to a disaster or emergency. The licensee's Emergency Preparedness Plan dated January 1, 2021, indicated the agency would have a written plan of action in place to assure the safety and well-being of clients [residents] and staff during periods of an emergency or disaster that disrupts services. No further information was provided.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is	{0 780}		

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{0 780}	Continued From page 8 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: No further information required.	{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: No further information required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency;	{0 810}		

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{0 810}	Continued From page 9 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further information required.	{0 810}		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE AND SURVEY RESULTS

Electronically Delivered

February 10, 2022

Administrator
Hyatt House LLC
231 Washington Street
Holdingford, MN 56340

RE: Project Number(s) SL28686012

Dear Administrator:

On January 10, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found not corrected at the follow-up evaluation completed on October 27, 2021, which resulted in a conditional license. The January 10, 2022, follow-up evaluation determined your agency had corrected some but not all of the state licensing orders. **Based on the improvements, the conditions on the license were removed, effective February 8, 2022, however non-compliance remains.**

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on August 19, 2021, found not corrected at the time of the October 27, 2021 and January 10, 2022 follow-up evaluations and subject to penalty assessment are as follows:

0340-Correction Orders-144g.30 Subd. 5 - $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 -$500.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - $500.00
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - $500.00

The details of the violations noted at the time of this follow-up evaluation completed on January 10, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the

correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993 .

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Maria King, RN
Interim Division Director

Minnesota Department of Health
Health Regulation Division

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{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28686012 On January 4, 2022, and January 10, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 19, 2021, and a revisit survey completed on October 27, 2021. At the time of the survey, there were nine (9) residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 340} SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	{0 340}		

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{0 340}	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on October 27, 2021, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	{0 340}		

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{0 340}	Continued From page 2 of the residents). The findings include: On January 10, 2022, at approximately 9:17 a.m., licensed assisted living director (LALD)-A stated she did not feel all corrections were made, but they (licensee) were getting there. During the revisit survey on January 10, 2022, a review of the licensee's policies and procedures, resident records, employee records, and interviews with LALD-A and registered nurse (RN)-B lacked evidence to indicate the licensee corrected all orders issued on October 27, 2021. No further information was provided.	{0 340}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}		

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{0 480}	Continued From page 3 This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 660} SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including completion of a two-step tuberculin skin test (TST) or other evidence of TB screening, such as a blood test, for two of four employees (unlicensed personnel (ULP)-M, ULP-N) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{0 660}		

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{0 660}	Continued From page 4	{0 660}		

safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

The licensee's Facility TB Risk Assessment dated March 19, 2021, identified a low risk level.

ULP-M and ULP-N were hired under the comprehensive home care license on December 28, 2020, and on July 22, 2021, respectively; both ULP began providing assisted living services on August 1, 2021. ULP-M and ULP-N's employee records lacked evidence of a two-step TST or other evidence of TB screening, such as a blood test.

On January 10, 2022, at approximately 9:17 a.m., licensed assisted living director (LALD)-A stated ULP-M and ULP-N were scheduled to have a blood test drawn this week. LALD-A stated ULP-M and ULP-N were working with residents.

The licensee's TB Prevention and Control policy dated August 1, 2021, noted prior to contact with residents, staff would be screened for TB with a TST or single interferon gamma release assey blood test.

The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a

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	28686	A. BUILDING: _____ B. WING _____	R 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYATT HOUSE LLC	231 WASHINGTON STREET HOLDINGFORD, MN 56340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 660}	Continued From page 5 negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients (residents). Baseline TB screening should be documented in the employee's record." No further information was provided.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	{0 680}		

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{0 680}	Continued From page 6 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written plan of action to facilitate the management of the resident's care and services in response to a natural disaster, such as storms or other emergencies that may disrupt the licensee's ability to provide care and services. In addition, the licensee failed to develop an all-hazards emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all nine (9) residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 10, 2022, at approximately 9:17 a.m. licensed assisted living director (LALD)-A stated the emergency preparedness plan and Appendix Z had not been completed, but it was on the plan to work on for today. The licensee's Emergency Preparedness Plan dated January 1, 2021, indicated the agency would have a written plan of action in place to assure the safety and well-being of clients and staff during periods of an emergency or disaster	{0 680}		

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{0 680}	Continued From page 7 that disrupts services. No further information was provided.	{0 680}		
{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: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff.	{0 780}		

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{0 780}	Continued From page 8 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 January 4, 2022, between 10:50 a.m. and 11:35 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, the following observations were made: 1. When sleeping room smoke alarms were tested in rooms 8 and 9 by LALD-A, none of the other smoke alarms within the dwelling unit were activated. The smoke alarm in the shared hallway for rooms 8 and 9 was not activated when LALD-A tested the smoke alarms in rooms 8 and 9. 2. When sleeping room smoke alarms were tested in rooms 10 and 11 by LALD-A, none of the other smoke alarms within the dwelling unit were activated. The smoke alarm in the shared hallway for rooms 10 and 11 was not activated when LALD-A tested the smoke alarms in rooms 10 and 11. 3. A smoke alarm was not installed in the hallway outside room 14 in the basement. During the tour interview with LALD-A, they confirmed the smoke alarms were not interconnected within the dwelling units 8/9 and 10/11. They also confirmed that a smoke alarm had not been installed in the hallway outside room 14.	{0 780}		

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{0 780}	Continued From page 9 No further information was provided.	{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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. 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 January 4, 2022, between 10:50 a.m. and 11:35 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, the following observations were made: 1. Oxygen was used by residents in rooms 2 and	{0 800}		

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{0 800}	Continued From page 10 4. Rooms were not provided with signage identifying that oxygen was used. LALD-A confirmed during the exit interview on January 4, 2022, at 11:55 a.m. that rooms where oxygen was used required signage. 2. The sidewalks were covered in snow outside two fire exit doors. LALD-A confirmed during the exit interview on January 4, 2022, at 11:55 a.m. that snow had not been removed from the fire exit sidewalks. 3. Carpet and light fixtures throughout the facility were soiled. LALD-A confirmed during the tour interview that they were currently working on cleaning the light fixtures and that the carpet would be cleaned next week. 4. In the lower day room, the wall under the baseboard heater was soiled and stained black. LALD-A confirmed during the tour interview that this wall was soiled and that they had cleaned this area previously, but the black stains came back. 5. In room 3, the exhaust fan in the bathroom had been removed. LALD-A confirmed during the tour interview that this exhaust fan had been removed and required replacement. 6. In the shared bathroom for room 10/11, there was a hole in the wall where a grab bar was previously installed. LALD-A confirmed during the tour interview that this area required repair. 7. In room 1, one ceiling tile in the corner of the room was stained. In room 10, one ceiling tile was cracked. LALD-A confirmed during the tour interview that these ceiling tiles required replacement. 8. Room identifiers were not provided on the outside of resident rooms 8, 9, 10, 11, 13, 14, 15, and 16. LALD-A confirmed during the exit interview on January 4, 2022, at 11:55 a.m. that these rooms were not provided with room identifiers.	{0 800}		

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{0 800}	Continued From page 11 No further information was provided.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year 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	{0 810}		

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{0 810}	Continued From page 12 by: Based on interview, the licensee failed to provide the required staff training and evacuation drill frequency for fire safety and evacuation. This had the potential to affect all residents 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 January 4, 2022, at approximately 11:50 a.m., survey staff requested documentation from licensed assisted living director (LALD)-A on staff training for fire safety and evacuation and evacuation drills. No documents were provided for review. On January 4, 2022, at approximately 11:55 a.m., LALD-A confirmed during the exit interview that the facility failed to provide the required staff training for fire safety and evacuation. LALD-A stated that the evacuation drill frequency requirement was not met. LALD-A stated that they were still working on creating policies and procedures to address staff training and evacuation drills. No further information was provided.	{0 810}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication	{01760}		

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{01760}	Continued From page 13 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure insulin administration via a prefilled insulin pen was according to manufacturer instructions, for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's insulin was not administered according to the manufacturer instructions. R1's prescriber orders dated December 15, 2021, included Novolog Flexpen (an injectable	{01760}		

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{01760}	Continued From page 14 medication for diabetes) 100 units (U) / milliliter (ml), inject 36 U three times daily with meals. R1's Service Plan Agreement dated December 23, 2021, identified services included, but were not limited to, medication administration. R1's January 2022, Medication Administration Record (MAR) listed medications as prescribed, times to administer, and staff initials on each date through January 9, 2022, to indicate the medications had been given. On January 10, 2022, at approximately 11:35 a.m. licensed assisted living director (LALD)-A was observed to assist R1 with insulin administration. LALD-A dialed the insulin pen to 36 U, and handed it to R1 to administer the insulin independently. After the pen was returned to the medication storage area, LALD-A confirmed the Novolog Flexpen had not been primed by dialing it to 2 U and ejecting the medication prior to dialing to the prescribed 36 U, and confirmed training had included this step. On January 10, 2022, at 11:50 a.m. registered nurse (RN)-B confirmed the insulin pen should be primed by wasting 2 U prior to dialing the prescribed dose. The manufacturer instructions for the use of Novolog insulin pen dated January 2019, directed for the insulin pen to be primed with 2 U prior to dialing the prescribed dosage. If this was not completed before each injection, too much or too little insulin may be administered. The licensee's undated Insulin Pen Medication Protocol with a Reusable Pen policy noted if required, prime the needle by following the	{01760}		

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{01760}	Continued From page 15 manufacturer instructions, which may include dialing 2 U of insulin, pressing the injection button, and watching for a drop of insulin to appear on the tip of the needle. No further information was provided.	{01760}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

November 10, 2021

Administrator
Hyatt House LLC
231 Washington Street
Holdingford, MN 56340

RE: Conditional License Number 404549
Health Facility Identification Number (HFID) 28686
Project Number(s) SL28686012

Dear Administrator:

The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility on October 27, 2021, to determine correction of orders on the evaluation completed on August 19, 2021. The follow-up evaluation determined your facility had not corrected all of the state licensing orders and you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90 day conditional license, effective date of this letter, and due to expire on **February 8, 2022**.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 27, 2021 follow-up evaluation and subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - $500.00
0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - $500.00
0490-Minimum Requirements-144g.41 Subd 1 (13) (ii)-(vii) - $500.00
0580-Quality Management-144g.42 Subd. 2 - $500.00
0640-Posting Information For Reporting Suspected C-144g.42 Subd. 7 - $500.00
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $3,000.00
0730-Contents Of Resident Record-144g.43 Subd. 3
0770-Minimum Site Requirements-144g.45 Subdivision 1 - $500.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - $500.00
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - $3,000.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - $500.00
0900-Contract Required-144g.50 Subdivision 1 - $500.00
0910-Contract Information-144g.50 Subd. 2 - $500.00

1470-Content Of Required Orientation-144g.63 Subd. 2 - $500.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1880-Storage Of Medications-144g.71 Subd. 19 - $500.00

The details of the violations noted at the time of this follow-up evaluation completed on October 27, 2021 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up evaluation completed on October 27, 2021, we identified the following violation(s):

0110-Assisted Living Director License Required-144g.10 Subdivision 1a - $3,000.00
0340-Correction Orders-144g.30 Subd. 5 - $500.00
0510-Infection Control Program-144g.41 Subd. 3 - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to144G.9999, **the total amount you are assessed is $16,000.00**

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

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

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

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

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

    i. A list of the names and birthdates of any individuals Hyatt House LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

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

representative

c. Consultant: Hyatt House LLC will contract with an RN to provide consultation concerning all clients to whom Hyatt House LLC provides licensed assisted living services under the conditional license. The consultant must have access to all clients receiving services from Hyatt House LLC The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Hyatt House LLC and MDH must review the RN's credentials and approve the selection. Hyatt House LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Hyatt House LLC in an effort to help Hyatt House LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. Hyatt House LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Hyatt House LLC and the RN consultant about a change. Each report will be electronically submitted to Jonathan Hill, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jonathan.hill@state.mn.us. Jonathan Hill can be reached at 651-201-3993 (office) with questions about reports. The content of the reports will include information such as:

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

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

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

g. **Corrective Action Plan:** Hyatt House LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

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

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Martha Burton, MPA
DIVISION DIRECTOR

Minnesota Department of Health
Health Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28686	A. BUILDING: _____ B. WING _____	R 10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYATT HOUSE LLC	231 WASHINGTON STREET HOLDINGFORD, MN 56340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL28686012 On October 25, 2021, through October 27, 2021, surveyors of this Department's staff conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 19, 2021. At the time of the survey, there were eleven (11) active residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.A 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.	
0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD). This had the potential to affect all eleven (11) residents receiving Assisted Living services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order. The findings include: On October 26, 2021, at 9:00 a.m. the Minnesota Board of Executives for Long-Term Services and Support website was checked for verification of unlicensed personnel (ULP)-A assisted living director licensure verification. ULP-A was not listed as having a current LALD license. On October 26, 2021, at 9:15 a.m. ULP-A confirmed her licensure application for assisted living director was still pending and was not sure why it was not yet approved.	0 110		

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0 110	Continued From page 2 The licensee lacked a LALD to manage and supervise Assisted Living services for the eleven current residents receiving assisted living services. ULP-A was hired on February 12, 2015, with the current title of housing manager. Licensing follow up survey conducted on October 25 through October 26, 2021, revealed a lack of oversight, supervision and management, as evidenced by: Issuance of Immediate correction order on October 25, 2021, at 144G42 (Business Operations) subdivision ten, related to fire hazards and lack of emergency disaster planning. ULP-A did not ensure space heaters were implemented according to manufacture's instructions and important safety warnings. ULP-A did not monitor the temperature of the facility to ensure resident comfort and safety, during failure of facility heating system. ULP-A did not take into consideration actions needed to ensure residents were free from fire hazards. ULP-A did not ensure an emergency disaster plan was developed and implemented to ensure safety of residents when the heating system failed, as far back as March, 2021. On October 26, 2021, at 11:15 a.m. ULP-A verified the above listed failures of management. The licensee's policy related to Assisted Living Directors was requested but not provided. On October 26, 2021, at 11:00 am. Registered Nurse (RN)-B confirmed the licensee lacked a policy related to Assisted Living Directors. No further information was provided	0 110		

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0 110	Continued From page 3 Time Period to correct: IMMEDIATE The immediacy of this order was not removed at the time of exit on October 27th, 2021.	0 110		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation and actions taken to comply with the correction	0 340		

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0 340	Continued From page 4 orders for a survey completed on August 19, 2021. This had the potential to affect all eleven residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: An Assisted Living licensing follow up survey was initiated on October, 25, 2021, to follow up on orders issued pursuant to an Assisted Living survey completed on August 19, 2021. On October 25, 2021, at 10:00 a.m., the surveyor requested documentation of actions taken to comply with the correction orders issued. An eighty-seven page 2567 report was presented, however, the documentation of actions taken to comply only addressed one order (0480). On October 25, 2021, at 10:15 a.m., unlicensed personnel (ULP)-A confirmed there was no documentation of actions taken to comply with the remaining thirty-four correction orders.ULP-A stated some orders were corrected without documentation of actions taken to comply. No further information was provided.	0 340		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}		

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{0 470}	Continued From page 5 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required staffing plan was developed and posted as required. This had the potential to affect all eleven residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a	{0 470}		

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{0 470}	Continued From page 6 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 lacked a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked - identify the direct-care staff member's resident assignments or work location - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building On October 25, 2021, at 10:40 a.m., an erasable white board was observed in the main area of the facility. The white board only listed two staff names per shift. The white board lacked all work shifts, including days and hours worked and failed to include staff member assignments. On October 25, 2021, at 11:00 a.m., registered nurse (RN)-B confirmed the staffing plan posted did not include all required content. She further stated, there were typically two staff per shift, one of which was responsible for medications, the other was responsible for meal preparation, as there was no cook. The licensee lacked a policy related to having a staffing plan. No further information was provided.	{0 470}		

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{0 480}	Continued From page 7	{0 480}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all eleven residents receiving Assisted Living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	{0 480}		

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{0 480}	Continued From page 8 The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated, October 26, 2021, for the specific Minnesota Food Code deficiencies.	{0 480}		
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have daily programs of social	{0 490}		

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{0 490}	Continued From page 9 and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all eleven residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's progress notes dated October 25, 2021, at 8:23 a.m., included the following entry: "Resident came to me this morning asking that I talk with other residents about needing things while they are playing bingo. I informed him that staff can not [sic] ignore a resident who needs assistance. And if the game needs to be paused that's what needs to happen. Resident cares come before the game." The entry was signed by unlicensed personnel (ULP)-A. On October 27, 2021, at 10:10 a.m., ULP-A confirmed there was no activity director and the staff on duty would occasionally need to pause activities to care for other resident's needs. The licensee's September Activity Schedule included 10 days where the only activity listed was a Twins Game on TV. The licensee lacked a policy related to recreational activities.	{0 490}		

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{0 490}	Continued From page 10 No further information was provided.	{0 490}		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. This had the potential to affect all eleven residents and all staff working at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 11 The findings include: The following substandard infection control issues were identified: Inadequate Covid-19 infection control practices. Presence of flies with no pest control plan in place. Mold visible from leaking roof. Inadequate Covid-19 Infection Control Practices. On October 25, 2021, at 11:20 a.m., unlicensed personnel (ULP)-J was observed to provide direct patient care (medication administration) for R1 without the use of eye protection. On October 25, 2021, at 11:40 a.m., registered nurse (RN)-B stated all staff were supposed to be wearing eye protection while in resident care areas. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade, well-fitting facemask and eye protection. The Minnesota Department of Health COVID-19 Toolkit, Information for Long-Term Care Facilities dated March 8, 2021, indicated to prevent unseen spread of COVID-19 staff actions to include, "use of eye protection (e.g., face shield, goggles) during all resident care encounters as a way to reduce COVID-19 exposure risk to staff. Eye protection is recommended when staff are in a resident care areas. Use of appropriate PPE can reduce staff exposures that might lead to exclusion from work".	0 510		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 12 On October 25, 2021, at 2:00 p.m., a visitor was allowed to enter the facility without prior symptom screening at the front door. Staff did not prompt the visitor to screen for Covid-19 symptoms. The licensee's "COVID-19 Preparedness Plan" revised August 11, 2021, lacked instruction for PPE use. The plan indicated visitors would be screened for COVID-19 symptoms prior to entrance. Pest Control On October, 25 and 26, 2021, throughout the day, multiple flies were observed in the activity room. On October 26, 2021, at 8:10 a.m., ULP-A confirmed there was no pest control contract in place and no traps had been placed in the kitchen. She also verified the trash bin directly outside of the kitchen was overflowing, stating trash removal would occur that day. The kitchen door was observed to be propped open as ULP-A went outside to smoke. Black Mold and Leaking Roof On October 25, 2021, at 11:00 a.m., ULP-A verified nothing had been done to address the visible mold on the walls and carpet within the facility. ULP-A also stated the roof had not been fixed and there was no contract in place for the repair. On October 25, 2021, at 11:00 a.m., moldy, broken pieces of ceiling tile were observed sitting in activity room. Additionally, a molding roll of paper was observed in activity room. Accepted Health Standard Reference from CDC Healthy Housing reference Manual chapter 5, Indoor Air Pollutants at	0 510		

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0 510	Continued From page 13 www.cdc.gov/healthyhomes/publications.html: Many molds produce numerous protein or glycoprotein allergens capable of causing allergic reactions in people. Certain molds can cause a variety of adverse human health effects, including allergic reactions and immune responses (e.g., asthma), infectious disease (e.g., histoplasmosis), and toxic effects (e.g., aflatoxin-induced liver cancer from exposure to this mold-produced toxin in food) [14]. Older, substandard homes could be particularly prone to mold problems because of inadequate maintenance e.g., inoperable gutters and roof leaks. In addition, people exposed to indoor air pollutants for the longest periods were often those most susceptible to their effects. Such groups include the young, the elderly,and the chronically ill, especially those suffering from respiratory or cardiovascular disease. The licensee's "Minnesota Bill of Rights for Assisted Living Residents" dated May 6, 2021, indicated, "Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health standards." R1's Hyatt House Lease Agreement dated July 13, 2020, and signed by R1 and ULP-A; under V. (B) on page seven, the agreement identified Hyatt House would maintain the resident's room in a fit and habitable condition, would maintain all common areas in a clean and structurally safe condition and would maintain all equipment, appliances and fixtures, and all electrical, plumbing, heating, ventilating and air conditioning equipment in good and safe working order and condition.	0 510		

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0 510	Continued From page 14 The licensee's policies related to environmental health concerns was requested but not provided. No further information was provided.	0 510		
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of a quality management activity. This had the potential to affect all eleven residents receiving Assisted Living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	{0 580}		

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{0 580}	Continued From page 15 The findings include: On October 26, 2021, at 9:10 a.m., RN-B confirmed there was no documentation of quality management activity. The licensee's Quality Assurance policy was requested but not provided. No further information was provided.	{0 580}		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all eleven residents receiving assisted living services.	{0 640}		

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{0 640}	Continued From page 16 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 lacked the following: - posting of the 911 emergency number in common areas and near telephones provided by the Assisted Living facility On October 25, 2021, at 10:30 a.m., the white telephone in the television room was observed and 911 emergency number was not on or near the phone. On October 27, 2021, at 10:00 a.m., registered nurse (RN)-B confirmed the white phone in the television room did not have the 911 emergency number posted on or near the phone. The licensee lacked a policy related to posting of the adult abuse reporting and emergency numbers. No further information was provided.	{0 640}		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	{0 660}		

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{0 660}	Continued From page 17 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of two unlicensed personnel (ULP-J, ULP-F) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F and ULP-J's records lacked evidence of screening for active TB.	{0 660}		

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{0 660}	Continued From page 18 ULP-F had a hire date of January 25, 2021, and worked the night shift (10:00 p.m. to 7:00 a.m.). ULP-F's record included a TB history and symptom screen, however was dated June 7, 2021, six months after hire. ULP-F had one negative TST dated June 7, 2021. ULP-F did not have a second TST. On October 26, 2021, at 12:00 p.m., RN-B confirmed the lack of a second TST for ULP- F. ULP-J had a hire date of October 4, 2021, and was observed to provide medication administration to R1 on October 25, 2021, at 11:20 a.m. ULP-J's record lacked evidence of a TB symptom screen or any TB testing. On October 26, 2021, at 12:00 p.m., RN-B confirmed the lack of TB testing and lack of baseline TB symptom screening for ULP-J. The licensee's TB Infection Control Program policy dated October 24, 2017, indicated baseline TB screening would be completed on hire for all health care workers. The policy also indicated baseline TB screening includes assessing for symptoms and testing for active TB. No further information was provided.	{0 660}		
{0 680} SS=I	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	{0 680}		

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{0 680}	Continued From page 19 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a written emergency disaster plan. In addtion, the licensee's building lacked a functional furnace (a heating unit used to heat up an entire building). The licensee implemented space heaters for nine of eleven residents, however, the space heaters were not implemented according to manufacturers instructions. This created a potential fire hazard that affected all eleven residents and all staff. This practice resulted in a level three violation (a violation that harmed a client's health or safety,	{0 680}		

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{0 680}	Continued From page 20 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). This resulted in an immediate correction order. The findings include: On October 25, 2021, at 11:30 a.m. unlicensed personnel (ULP) -A confirmed the heat for the assisted living building had not been repaired. A contract was requested but not provided. ULP-A did provide a name and phone number for the person they identified as working to identify and fix the heating failure. Fire Safety Hazards On October 25, 2021, at 11: 15 a.m. observations reveal resident (R)-1 had a small white square space heater plugged into an extension cord and the space heater was sitting on top of a wicker basket. On October 25, 2021, at 11:20 a.m. a space heater was observed in the hallway to the residents rooms and it was five inches from the wallpapered wall. On October 25, 2021, at 1:05 p.m. a space heater was observed in R-7's room three inches away from a brown sweater hanging on a hanger. All of the space heaters were turned on to the high setting. On October 25, 2021, at 1:20 p.m. ULP-A stated some residents have space heaters and some residents don't.	{0 680}		

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{0 680}	Continued From page 21 ULP-A stated, "We only provide space heaters if they request it." ULP-A was asked for the manufacturers instructions for the space heater and had to pull these from the empty box in storage. ULP-A was not aware of the caution label nor the hazard warnings and basic precautions. On October 25, 2021, at 1:00 p.m. R-10, stated he does not have a space heater in his room and stated he was cold, especially at night. The National Weather Center forecast for Holdingford, Minnesota indicated a low temperature of 33 degrees Fahrenheit for the evening of October 25, 2021. On October 25, 2021, at 3:10 p.m. person K (proposed furnace repairman) indicated via telephone that he does not have a contract with the assisted living licensee owner. He is in communication with the owner of the building (Person L) who lives in California. Person K indicated there was no specific plan at this time as to how or when the heat will be repaired. He stated it would be at least several months before the heating could be fixed. On October 25, 2021, RN-B stated the furnace to the building has not worked since March of 2021. The licensee's undated Emergency Preparedness in Assisted Living Emergency Plan, indicated on page ten, "If lack of heat is a concern, the Incident Commander will determine when and if residents may need to be evacuated to another location". The plan failed to address use of space heaters. The DeLonghi Electric oil filled radiator Model	{0 680}		

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{0 680}	Continued From page 22 EW7707CMC manufacture's instructions indicated the heater is hot when in use, keep combustible materials, such as furniture, pillows, bedding, papers, clothes and curtains at least 3 feet from the front, top, sides and rear of the heater. The instructions also included: Be sure that no other appliance is plugged into the same outlet and always plug heater directly into wall outlet, never use with an extension cord. No further information was provided. Time Period to correct: IMMEDIATE The immediacy of this order was not removed at the time of exit on October 27th, 2021.	{0 680}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;	{0 730}		

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{0 730}	Continued From page 23 (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the resident record included documentation of significant changes in the resident's status and action taken in response to the needs of the resident after a change in condition, for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	{0 730}		

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{0 730}	Continued From page 24	{0 730}		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).
The findings include:
R1's record lacked documentation of significant changes in R1's condition and actions taken in response to the needs of R1.

R1 was admitted on July 13, 2020, with diagnoses that included diabetes.

R1's progress notes were reviewed. On October 20, 2021, ULP-J documented a care worker called to convey R1 had concerns about his blood sugars and indicated they had been low when he leaves. There was no documentation the information was relayed to the registered nurse and no documentation of follow up to R1's concerns.

On October 26, 2021, at 10:21 a.m., RN-B confirmed ULP-J never contacted her in regard to R1's concerns related to low blood sugars and verified R1's record lacked documentation of actions taken in response to the needs of R1.

On October 25, 2021, at 11:20 a.m., a bottle of glucose (sugar) tabs were observed in R1's room. R1 stated he bought them himself.

R1's Blood Sugar report was reviewed. On October 20, 2021, at 5:03p.m., R1's blood sugar was recorded as 89. Normal for a person with diabetes is 80-130.

On October 25, 2021, at 11:40 a.m., RN-B denied knowledge that R1 had a bottle of glucose tabs in

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{0 730}	Continued From page 25 his room and confirmed there was no prescriber's order for R1 to self-administer medications. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated August 1, 2021, indicated the RN would re-assess the resident if there was a change in condition and update the service plan as necessary based on the resident's needs. No further information was provided.	{0 730}		
{0 770} SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on observations and interview, the licensee failed to provide space for outdoor activities for residents. This had the potential to directly affect the well-being of all eleven	{0 770}		

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{0 770}	Continued From page 26 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), 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 October 25, 2021, at 12:45 p.m., there was no designated outdoor activity area for residents. On October 27, 2021, at 10:10 a.m., ULP-A confirmed there had been no changes to address a designated outdoor activity area for residents. The licensee lacked a policy related to outdoor activity space. No further information was provided.	{0 770}		
{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;	{0 780}		

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{0 780}	Continued From page 27 (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: Based on observation and interview, the licensee failed to provide and maintain smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and all 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 October 26, 2021, between 11:00 a.m. and 12:00 p.m., survey staff toured the facility with unlicensed personnel (ULP) -A, During the tour, the following new observations were made: 1. A smoke alarm was not provided in resident sleeping room of dwelling unit 12 located in basement. ULP -A confirmed during tour interview	{0 780}		

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{0 780}	Continued From page 28 that smoke alarm was missing from dwelling unit 12. 2. Smoke alarm was not installed in dwelling unit 3. An empty smoke alarm bracket was observed. ULP -A confirmed during tour interview that a smoke alarm had been removed from this bracket. ULP -A explained that dwelling unit 3 was currently being used for storage and as a shower room for residents. On October 26, 2021, between 11:00 a.m. and 12:00 p.m., survey staff toured the facility with unlicensed personnel (ULP) -A. During the tour, the following observations were made for items that were not addressed from the prior survey on August 17, 2021: 1. Smoke alarm power light was not illuminated in main hallway near dwelling units 8/9. ULP -A confirmed during tour interview that hallway smoke alarm did not work. 2. Smoke alarms were not installed in main hallway of basement. Three empty smoke alarm brackets were observed. ULP -A confirmed during tour interview that smoke alarms were not provided in basement hallway. 3. Smoke alarms were not installed outside each seperate sleeping area in the immediate vicinity of bedrooms for combined dwelling units 8/9 and 10/11. ULP -A confirmed during tour interview that smoke alarms were not provided in these areas. No further information was provided.	{0 780}		
{0 800} SS=I	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	{0 800}		

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{0 800}	Continued From page 29 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 keep the physical environment, 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 when the heating system failed with no inspection or repairs. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order. The findings include: On October 26, 2021, between 11:00 a.m. and 12:00 p.m., during a tour of the facility with unlicensed personnel (ULP) -A, space heaters were observed in all of the occupied resident rooms and in common spaces throughout the facility. During an interview with ULP-A, on October 26, 2021 at approximately 11:15 a.m., ULP-A explained that the facility was not provided with	{0 800}		

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{0 800}	Continued From page 30 centralized heat, and the boiler system was broken. ULP-A stated that bids were received to repair or replace the old boiler system but the building owner had not agreed to move forward with repairs or replacement of the boiler system. At approximately 12:05 p.m., records were provided by registered nurse (RN) -B . Records were reviewed on October 26, 2021 between 12:05 p.m. and 12:10 p.m. by survey staff. Records included two quotes for replacement of the boiler and installation of a new centralized heat system. One quote was dated 09/09/2021 from SCR and the other dated 09/17/2021 from Shane Staugysta Plumbing. During an interview with RN-B, at approximately 12:10 p.m., RN-B stated that the building owner has not accepted either bids for replacment of the facility heating system. RN-B explained that if the bid from Shane Staugusta Plumbing was approved by the building owner, that the anticipated date for the centralized heat to be installed would be in one to one and a half months. RN-A explained that the building owner must approve replacement or repair of the centralized heat system before work can begin. A policy was requested and not provided. Time Period to Correct: IMMEDIATE The immediacy of this order was not removed at the time of exit on October 27th, 2021. The licensee did not keep facility environment, including walls, exhaust fan, resident's shower and ceiling in good repair.	{0 800}		

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{0 800}	Continued From page 31 On October 26, 2021, between 11:00 a.m. and 12:00 p.m., survey staff toured the facility with ULP-A. During the tour, the following new observations were made: 1. A hole was observed in the ceiling on two sides of the smoke alarm installed in dwelling unit 1. ULP -A confirmed during tour interview that ceiling required repair. 2. Exhaust fan in bathroom was not provided with a cover in dwelling unit 2. ULP -A confirmed during tour interview that exhaust fan cover was missing. 3. Shower head not provided in dwelling unit 6. ULP -A confirmed during tour interview that shower head was missing. 4. Ceiling tiles were missing in laundry room and in hallway between shared dwelling units 8 and 9. ULP -A confirmed during tour interview that some ceiling tiles were missing within the facility. On October 26, 2021, between 11:00 a.m. and 12:00 p.m., survey staff toured the facility with ULP-A. During the tour, the following observations were made for items that were not addressed from the prior survey on August 17, 2021: 1. Exhaust fan in bathroom was dusty and not provided with a cover in dwelling unit 7. ULP -A confirmed during tour interview that exhaust fan cover was missing. 2. Carpet and light fixtures throughout facility soiled. ULP -A confirmed during tour interview that some items from previous survey had not been addressed. 3. Ceiling tiles missing in lower day room. ULP -A confirmed during tour interview that some ceiling tiles were missing within the facility. No further information was provided.	{0 800}		

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{0 810}	Continued From page 32	{0 810}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the required staff	{0 810}		

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{0 810}	Continued From page 33	{0 810}		

training and evacuation drill frequency for fire safety and evacuation. This had the potential to affect all residents and all 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 October 26, 2021, at approximately 12:00 p.m., unlicensed personnel (ULP) -A and registered nurse (RN) -B provided records for review.
Records were reviewed by survey staff on October 26, 2021, between 12:00 p.m. and 12:30 p.m. The following items were not addressed from the prior survey on August 17, 2021:
1. The Fire Safety Policy dated January 15, 2018 failed to include the required frequency for evacuation drills, Procedure: 7 states drills at each residence at least every six (6) months.
2. The Emergency Preparedness policy dated January 15, 2018 failed to provide the required staff training frequency. The plan required staff training for fire safety and evacuation during orientation and then annually but did not require training at least twice per year after hire.
Examples of staff fire safety and evacuation employee training checklists were provided.

On October 26, 2021, at approximately 2:50 p.m., ULP -A confirmed during interview that the facility failed to provide the required staff training and evacuation drill frequency requirements for fire

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{0 810}	Continued From page 34 safety and evacuation. No further information was provided.	{0 810}		
{0 900} SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon	{0 900}		

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{0 900}	Continued From page 35 agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute an Assisted Living contract for ten of eleven residents receiving Assisted Living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's record lacked a written contract with the following required content: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a	{0 900}		

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{0 900}	Continued From page 36 complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. On October 26, 2021 at 9:10 a.m., registered nurse (RN)-B confirmed R9 was the only resident with an executed assisted living contract and verified ten of eleven residents did not have an assisted living contract implemented. The licensee lacked a policy and procedure addressing assisted living contracts. No further information was provided.	{0 900}		
{0 910} SS=F	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address,	{0 910}		

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{0 910}	Continued From page 37 which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for ten of eleven 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's record lacked a written contract with the following required content: (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility;	{0 910}		

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{0 910}	Continued From page 38 (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. On October 26, 2021, at 9:10 a.m., registered nurse (RN)-B confirmed R9 was the only resident with an executed assisted living contract and verified ten of eleven residents lacked an assisted living contract implemented with all required content. The licensee lacked a policy and procedure addressing assisted living contract. No further information was provided.	{0 910}		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of	{01470}		

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{01470}	Continued From page 39 complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing	{01470}		

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{01470}	Continued From page 40 requirements and regulations for two of two unlicensed personnel (ULP-J, ULP-F) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-J and ULP-F's employee records lacked evidence to indicate the employees had received orientation to include the following topics: - an overview of Assisted Living laws 144G. - an introduction and review of the facility's policies and procedures related to the provision of Assiste Living services by the individual staff person - handling of emergencies and use of emergency services - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	{01470}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28686	A. BUILDING: _____ B. WING _____	R 10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01470}	Continued From page 41 Services, county-managed care advocates, or other relevant advocacy services - a review of the types of assisted living services the employee would be providing and the facility's category of licensure ULP-J's hire date was October 4, 2021. ULP-F's hire date was January 25, 2021. Both employee records lacked evidence of having completed the orientation list above. On October 26, 2021, at 12:40 p.m., registered nurse (RN)-B verified the orientation had not been completed/corrected yet. The licensee's Assisted Living & Assisted Living with Memory Care Orientation - All Staff policy, dated June 1, 2021, noted all employees must complete orientation to include: - overview of Minnesota's assisted living law - introduction and review of the licensee's policies and procedures related to the provision of assisted living services - emergency and disaster training - the assisted living bill of rights - principles of person-centered planning and service delivery - types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and the licensee's scope of licensure - consumer advocacy services No further information was provided.	{01470}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	{01760}		

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{01760}	Continued From page 42 living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for one of one resident (R1) reviewed for 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: R1 did not receive the correct dose of insulin. R1 had a prescriber order dated, September 30, 2021, for Novolog Flexpen 100u/ml (units per milliliter). Inject 36 units SQ (subcutaneous) 3 times daily with meals. On October 25, 2021, at 11:20 a.m., unlicensed personnel (ULP)-J took two Flexpens into R1's room as the opened Flexpen only had 7 units left	{01760}		

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{01760}	Continued From page 43 in it. ULP-J dialed up the first Flexpen to 7 units and handed the pen to R1 who self-administered the medication into his abdomen. R1 did not use an alcohol wipe on the injection site prior to administering the insulin and ULP-J did not prompt R1 to use an alcohol wipe. ULP-J then dialed up 24 units of insulin with the new Flexpen and handed it to R1 who self-administered to the abdomen, again no alcohol wipe. The surveyor asked ULP-J what 24 and 7 totaled and ULP-J confirmed the two doses only added up to 31 units, not the prescribed 36 units. ULP-J then proceeded to go get another needle to dial up five more units of insulin. ULP-J verified the medication error stating that she was nervous. On October 25, 2021, at 11:40 a.m., registered nurse (RN)-B was informed of the medication error and filled out an error report, and indicated ULP-J would need re-education. ULP-J's employee record was reviewed and included practical skills competency testing by RN-B on insulin and blood glucose monitoring dated October 6, 2021. ULP-J passed the skills testing and was deemed competent by RN-B. The licensee's Medication Administration policy dated, March 10, 2017, indicated the RN may delegate medication administration to an unlicensed staff member if they have passed a competency evaluation with respect to all routes. Although the policy recapitulated regulatory language, the policy lacked a procedure to address a system for ensuring medications were administered safely.	{01760}		

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{01760}	Continued From page 44 No further information was provided.	{01760}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and would permit only authorized personnel access, this had the potiential to affect all 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), 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 October 25, 2021, at 11:20 a.m., unlicensed personnel (ULP)-J removed the key to the medication cabinet from an unlocked drawer directly beneath the locked medication cabinet. On October 25, 2021, at 11:45 a.m., registered nurse (RN)-B confirmed staff are supposed to keep the key on their person and should not be storing the key to the medication cabinet in an	{01880}		

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{01880}	Continued From page 45 unlocked drawer. The licensee's Storage of Medications policy dated, March 10, 2017, indicated only authorized personnel would have access to the stored medications. No further information was provided.	{01880}		

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

Type: Follow-Up
Date: *10/26/21*
Time: 11:05:05
Report: 7930211181

Food and Beverage Establishment Inspection Report

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

Establishment Info:
ID #: 0037490
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207469902
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

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

ORDER ORIGINALLY WRITTEN ON 8/17/21. 10/26/21: 0PPM CHLORINE IN DISHWASHER FINAL RINSE. QUATERNARY AMMONIA WAS USED IN PLACE OF CHLORINE. QUAT IS NOT APPROVED FOR DISHWASHERS. REPLACE WITH CHLORINE & REPAIR TO WORKING CONDITION.

Comply By: 10/26/21

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

ORDER ORIGINALLY WRITTEN ON 8/17/21. 10/26/21: HANDWASHING SINK HAS A SLOW DRAIN AND IS NOT DRAINING PROPERLY. MANAGER HAS TRIED FIXING THE DRAIN AND IT HAS NOT BEEN REPAIRED. IF MANAGER IS UNABLE TO UNPLUG THE DRAIN A PLUMBER MUST BE CALLED.

Comply By: 10/26/21

6-300 Physical Facility Numbers and Capacities

6-303.11C

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

ORDER ORIGINALLY WRITTEN ON 8/17/21. 10/26/21: THERE ARE SEVERAL BULBS IN LIGHT FIXTURES THROUGHOUT THE KITCHEN THAT ARE BURNED OUT. REPLACE BULBS.

Comply By: 10/26/21

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

UNTIL DISHWASHER IS REPAIRED, DISHES MUST BE SANITIZED IN THE THREE COMPARTMENT SINK.

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 7930211181 of 10/26/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____ Establishment Representative

Signed:_____ Inspector ID #7930

651-201-4500
health.foodlodging@state.mn.us

Electronically Delivered

September 28, 2021

Administrator
Hyatt House LLC
231 Washington Street
Holdingford, MN 56340

RE: Project Number(s) SL28686012

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 19, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) Fire Protection And Physical Environment - $3,000.00

St - 0 - 0810 - 144g.45 Subd. 2 (b)-(f) Fire Protection And Physical Environment - $3,000.00

St - 0 - 0820 - 144g.45 Subd. 2 (g) Fire Protection And Physical Environment - $3,000.00

The total amount you are assessed is $9,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

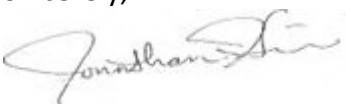
Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project #SL28686012 On August 17 through August 19, 2021, 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 nine (9) residents receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care 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=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours 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 residents access to food at any time. This had the potential to affect all nine residents. 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: Resident (R1) and R2 had diagnoses including	0 460		

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0 460	Continued From page 2 but not limited to diabetes. During observations in the dining room on August 17, 2021, through out the day, no snacks were offered to residents in between meals. On August 17, 2021, at 2:20 p.m., R4, R5, and R6 confirmed they do not have access to snacks in between meals. They stated they were instructed by staff to wait until 9:00 p.m. for a snack. When asked about water, R4 indicated they can get water whenever they want from the tap but there was no ice/water machine or pop machine. R4 indicated the tap water tastes better if it is refrigerated first. On August 18, 2021, at 2:00 p.m., unlicensed personnel (ULP)-A confirmed staff put tap water in the refrigerator for residents. ULP-A stated they were not aware staff were telling residents they had to wait till 9:00 p.m. for a snack. The licensee's undated Minnesota Bill of Rights for Assisted Living Residents policy, indicated under Rights #15, "Residents have the right to access food at any time." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;	0 470		

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0 470	Continued From page 3 (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required staffing plan was developed and posted as required. This had the potential to affect all nine residents, staff, and visitors. 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	0 470		

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HYATT HOUSE LLC	231 WASHINGTON STREET HOLDINGFORD, MN 56340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 4 a large portion or all of the clients). The findings include: The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked - identify the direct-care staff member's resident assignments or work location - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building On August 17, 2021, at 10:00 a.m., no posted staff schedule was observed in the main entry area of the facility or two hallway areas. On August 18, 2021, at approximately 3:30 p.m., regisered nurse (RN)-B confirmed no staffing plan had been developed or staffing schedule posted as required. The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Minimum requirements (13) offer to provide or make available at least the following services to residents:	0 480		

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0 480	Continued From page 5 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all nine residents. 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: Please refer to the additional documentation	0 480		

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0 480	Continued From page 6 included in the Food and Beverage Establishment Inspection Reports, dated August 17, 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 490 SS=F	144G.41 Subdivision 1. (13) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities	0 490		

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0 490	Continued From page 7 for active participation in the community at large. This had the potential to affect all nine residents of the facility. 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: The licensee lacked a daily program of activities as required. Observations on August 17, 18, and 19, 2021, revealed no activities were planned or offered. Some residents remained in their room all day and some sat outside the front door all day. On August 17, 2021, at 2:20 p.m. R4, R5 and R6 confirmed there were no activities offered. On August 18, 2021, at approximately 3:30 p.m., registered nurse (RN)-B confirmed an activity program had not been developed with the required content. The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		

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0 510	Continued From page 8	0 510		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. This had the potential to affect all nine residents and all 18 staff working at the facility. 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: The following substandard infection control issues were identified:	0 510		

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0 510	Continued From page 9 Inadequate Covid-19 infection control plan. Infestation of flies and rodents with no pest control plan in place. Mold visible from leaking roof . Handwashing breaches. Hauling trash through the kitchen. Inadequate Covid-19 infection control practices. On August 17 and 18, 2021, through out the day, unlicensed personnel (ULP)-A, ULP-C, and ULP-D were observed to provide direct patient care without eye protection. On August 18, 2021, at 3:30 p.m. registered nurse (RN)-B indicated she was unaware of the current COVID-19 health care worker personal protective equipment recommendations. The surveyor provided the RN with the current recommendations. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well fitting facemask and eye protection. The Minnesota Department of Health COVID-19 Toolkit, Information for Long-Term Care Facilities dated March 8, 2021 indicated to prevent unseen spread of COVID-19 in your facility staff actions include the "use of eye protection (e.g., face shield, goggles) during all resident care encounters as a way to reduce COVID-19 exposure risk to staff. Eye protection is recommended when staff are in a resident care areas . Use of appropriate PPE can reduce staff exposures that might lead to exclusion from work".	0 510		

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0 510	Continued From page 10 The licensee's "COVID-19 Preparedness Plan" revised August 11, 2021, lacked instruction on PPE use. Vectors and Pests On August 17 and 18, 2021, through out the day, the inside of the Assisted Living facility was observed to be infested with multiple flies. There were multiple live flies and multiple dead flies observed through out the facility. The front door and side staff door were observed propped open the entire day. On August 17, 2021, at 2:00 pm ULP-A verified the flies were a problem and indicated the doors were left open to facilitate air flow as the building did not have central air conditioning and only had window units in resident rooms and some common areas. ULP-A verified the lack of a Pest Control contracted provider. On August 17, 2021, at approximately 1:45 pm , ULP-A, persons H and I (MDH engineering specialists) observed a rodent in the kitchen that was believed to be a mouse. Accepted Health Standard Reference from CDC Healthy Housing reference Manual chapter 4. Disease Vectors and Pest at www.cdc.gov/healthyhomes/publications.html: In general, the presence of flies was a sign of poor sanitation. Some of the disease-causing agents transmitted by houseflies to humans were Shigella (dysentery and diarrhea = shigellosis), Salmonella (typhoid fever), Escherichia coli, (traveler's diarrhea), and Vibrio cholera (cholera). Integrated pest management (IPM) techniques were necessary to reduce the number of pests that threaten human	0 510		

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health and property.
The standard further noted rodents destroy property, spread disease, compete for human food sources, and were aesthetically displeasing. Rodent-associated diseases affecting humans include plague, murine typhus, leptospirosis, rickettsialpox, and
rat-bite fever. Integrated pest management (IPM) techniques were necessary to reduce the number of pests that threaten human health and property.

Black mold like substance and leaking roof
On August 17, 2021, at 11:00 a.m. the common area activity room was observed to have black mold like staining on the following items:
Wooden window frames on the upper part of all window frames.
Two broken ceiling tiles that had fallen onto the floor.
A four foot roll of wet white paper with visible black mold like staining through-out.
In addition, there were two clear plastic buckets (12 inches long) on the window sill with 2 inches of brownish black liquid with dead flies in it.
On August 17, 2021, at 1:00 p.m. ULP-A verified the substance was most likely water from the leaky roof. ULP-A confirmed the roof was in bad disrepair and there was no contract in place to repair the roof. ULP-A stated she had requested the owner make upgrades to the building, but the requests were denied. ULP-A confirmed residents (R7 and R8) had compromised respiratory systems because of diagnoses of chronic obstructive pulmonary disease and were on oxygen therapy.

Accepted Health Standard
Reference from CDC Healthy Housing reference Manual chapter 5, Indoor Air Pollutants at www.cdc.gov/healthyhomes/publications.html:

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Many molds produce numerous protein or glycoprotein allergens capable of causing allergic reactions in people.
Certain molds can cause a variety of adverse human health effects, including allergic reactions and immune responses (e.g., asthma), infectious disease (e.g., histoplasmosis), and toxic effects (e.g., aflatoxin-induced liver cancer from exposure to this mold-produced toxin in food) [14].
Older, substandard homes could be particularly prone to mold problems because of inadequate maintenance e.g., inoperable gutters and roof leaks. In addition, people exposed to indoor air pollutants for the longest periods were often those most susceptible to their effects. Such groups include the young, the elderly,and the chronically ill, especially those suffering from respiratory or cardiovascular disease.

Substandard Handwashing
On August 17, 2021, at approximately 2:15 p.m. ULP-E was observed to enter R2's room to answer a call light. Upon entry ULP-E donned gloves assisted R2 to transfer onto the toilet. Approximately 10 minutes later, ULP-D also entered R2's room and assisted the client to change incontinent product, provide perineal care and transfer back into the wheelchair. Upon completion of the tasks, and with soiled gloved hands, ULP-E carried the trash through the kitchen and into the dumpster. ULP-D then joined ULP- E in the kitchen where both employee removed the gloves they had on when assisting R2. Without hand hygiene after removal of the soiled gloves, both ULP-D and ULP-E donned a new pair of gloves in the kitchen and began immediately to gather food items for resident's afternoon snack. Neither ULP-D nor ULP-E washed their hands after removing the

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0 510	Continued From page 13 gloves used while assisting R2. When asked about glove use and handwashing (hand hygiene) at approximately 2:37 p.m. ULP-D stated "we should have" washed their hands with soap and water. ULP-E stated, "I think we just forgot." ULP-D and ULP-E both stated they knew one of the times hands needed to be washed was after removing gloves. Review of ULP-D's and ULP-E's training records indicated they were trained on infection control techniques/handwashing on October 13, 2016, and August 13, 2021, respectively. On August 19, 2021, at approximately 10:37 a.m. registered nurse (RN)-B stated a "cardinal rule" for handwashing was after removal of gloves and added the employees who disposed of the trash, then started on the snacks "should have washed their hands" before putting on the new pair of gloves. RN-B stated handwashing was part of all employee orientation and ongoing training. The licensee's Handwashing policy dated July 19, 2018, indicated handwashing would be performed routinely and thoroughly to protect residents from the spread of infection. The policy lacked specifications when handwashing was to occur. Disposal of Trash Issue On August 17, 2021, at approximately 2:15 p.m., ULP-E and ULP-D were observed to assist R2 with transfers, toileting and perineal care, including disposal of the resident's incontinent products in the trash in the resident's room. ULP-E exited the room, with gloved hands, and carrying a trash bag. ULP-E carried the trash down the hallways, then entered the facility's kitchen, walked past the prep tables and exited	0 510		

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0 510	Continued From page 14 the kitchen out the side door with the trash, and tossed the trash bag into the dumpster, located just outside and near the kitchen door exit. ULP-E and ULP-D verified they removed trash on a daily basis, stating we walk "right through the kitchen." ULP-D stated going through he kitchen was "really the only way" to take the trash out, and if they did not go that way, they would have to go out the front door, and then around to this side of the building. ULP-D stated this was how she "always" removed trash from the building and into the dumpster. On August 18, 2021, at approximately 8:53 a.m., ULP-F was observed exiting a resident's room, carrying bagged trash, and took the bagged garbage through the facility's kitchen and out the kitchen door to the nearby dumpster. ULP-F stated "that's how I typically carry out the trash." ULP-F stated this was how they had to do because the garbage can is right outside the kitchen, in the alley. On August 18, 2021, at approximately 3:56 p.m., registered nurse (RN)-B confirmed staff routinely carried out resident garbage bags through the kitchen, to get them tossed into the dumpster. RN-B stated, "I never thought about that." and stated she realized it was "not a good infection control practice." RN-B stated the garbage dumpster has always been there, and stated she understood the facility did not want to move the dumpster; RN-B stated "we'll have to come up" with a different way to properly dispose the trash. On August 18, 2021, at 3:30 p.m. RN-B verified the leaking roof, black mold like substance/staining and pest concerns were a health risk to the residents.	0 510		

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0 510	Continued From page 15 The licensee's "Minnesota Bill of Rights for Assisted Living Residents" dated May 6, 2021, indicated "Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health standards." The licensee's policies related to environmental health concerns was requested but not provided. R1's Hyatt House Lease Agreement dated July 13, 2020, and signed by R1 and ULP-A; under V. (B) on page seven, the agreement identified Hyatt House would maintain the residents room in a fit and habitable condition, would maintain all common areas in a clean and structurally safe condition and would maintain all equipment, appliances and fixtures, and all electrical, plumbing, heating, ventilating and air conditioning equipment in good and safe working order and condition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional	0 550		

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0 550	Continued From page 16 Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This had the potential to affect all nine 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: On August 17, 2021, at 10:10 a.m. observations revealed the licensee lacked a posting of the above required content. On August 18, 2021, at 3:35 p.m. registered	0 550		

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0 550	Continued From page 17 nurse (RN)-B confirmed the required content noted above had not been posted as required. The licensee's "Complaint Policy and Procedure" dated August 16, 2021, lacked information regarding posting of the facility's grievance procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all nine residents receiving assisted living services. This practice resulted in a level two violation (a	0 580		

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0 580	Continued From page 18 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: On August 17, 2021, at 10:30 a.m. the licensees "QA Binder" was reviewed and the last documentation of any quality management activity was dated December 18, 2017, and was titled "Quality Improvement Committee Meeting." On August 18, 2021, at 3:40 p.m. registered nurse (RN)-B confirmed there was no current documentation of quality management activity. The licensee's Quality management policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be	0 630		

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0 630	Continued From page 19 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 updated for one of two residents (R1) with records reviewed. 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's most recent nursing assessment dated July 7, 2021, completed by registered nurse (RN)-B identified the resident was high risk for falls and required fall risk safety checks. R1's "Vulnerability, Safety & Risk" admission assessment dated July 13, 2020, was not updated to included staff identified vulnerabilities. R1's service plan dated August 5, 2021, indicated R1 was independent with transfers, but needed physical assist of one for ambulation. R1's "Progress notes" dated August 1, 2021, through August 17, 2021, included multiple entries of R1 leaving the facility with his girlfriend. On August 6, 2021, unlicensed personnel	0 630		

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0 630	Continued From page 20 (ULP)-A documented in the progress notes that R1 had gotten into an argument with his significant other and she dropped him off on the side of the road and resident was walking back to Hyatt House when he fell, hit his head and lost consciousness. On August 18, 2021, at 3:45 p.m. RN-B verified R1's individual abuse prevention plan was not updated to address newly identified vulnerabilities related to the significant other. The licensee's "Vulnerable Adult/Child Protection" policy dated August 8, 2021, included, "In compliance with Minnesota statutes, all Hyatt House, LLC employees are required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable	0 640		

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0 640	Continued From page 21 adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all nine 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: The licensee lacked the following: - post the 911 emergency number in common areas and near telephones provided by the Assisted Living facility - post information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557 On August 17, 2021, at approximately 10:00 a.m. upon arriving at the facility, an observation was made of the main entry area and common area and noted to lack the required posted information.	0 640		

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0 640	Continued From page 22 On August 18, 2021, at approximately 3:50 p.m., RN-B confirmed the required content noted above had not been posted as required. The licensee lacked a policy related to posting of the adult abuse reporting and emergency numbers. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance 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	0 650		

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0 650	Continued From page 23 required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (ULP-F, ULP-D) with employee records reviewed. 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 an isolated scope (when one or a limited number of clients 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 August 17, 2021, at approximately 10:29 a.m., unlicensed personnel (ULP)-A stated the licensee provided assisted living services, among which included: medication management, housekeeping and laundry and assistance with activities of daily living. Employee A said the licensee also provided treatment management services including things like oxygen and monitoring residents' blood sugars. Employee A stated medication administration and treatments were performed by unlicensed personnel, who were	0 650		

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0 650	Continued From page 24	0 650		

trained and signed off by the registered nurse to do those tasks. Employee A added employees should have in their file a record of having been trained.

ULP-F's employee record lacked evidence he had been trained and competency tested on delegated nursing tasks of medication administration or any treatments. ULP-F was assigned the night shift.
On August 18, 2021, at 3:50 p.m. registered nurse (RN)-B confirmed ULP-F was assigned medication administration and verified the employee record lacked training and competency testing on core skills and the delegated nursing task of medication administration.

ULP-D's record lacked evidence of having been trained and competency tested on injections, to include the administration of insulin.

On August 17, 2021, at approximately 2:15 p.m., ULP-D was observed to provide assisted living services for R2 when she assisted with toileting and changing of the resident's brief, then later transferred the resident. At approximately 2:43 p.m., ULP-D stated she had received training to pass medications, use a Hoyer (kind of mechanical lift) and also how to do blood sugars, and other skills. ULP-D stated she did these tasks on a daily basis.

Review of R2's medication administration record (MAR) for August 2021, indicated ULP-D administered medications and obtained R2's blood sugar on numerous occasions.

On August 18, 2021, at approximately 3:37 p.m. RN-B stated "we do skills and medications" sign off of the employees, and stated she completed

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0 650	Continued From page 25 "some" of the medication skills for ULP-F. RN-B acknowledged she did not know why there were not part of the employee records. RN-B also stated there should be a tested skill for each task, and if skills were missing from employee records, stated "I don't know why." The licensee's "Personnel [Employee] Records" policy dated November 1, 2016, indicated employee records for each paid employee would be maintained. The policy indicated documentation in the employee record would include documentation of competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

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0 660	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of two employees (ULP-D, ULP-F) with employee records reviewed. 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Unlicensed personnel (ULP)-D was hired by the licensee on October 22, 2020, to provide direct care services. On August 17, 2021, at approximately 2:17 p.m., ULP-D was observed to provide assisted living services and assisted R2 with toileting. ULP-D's employee records lacked evidence of baseline TB history and symptoms screens or having evidence of being screened for active TB with either a two-step TST or blood test. ULP-F had a hire date of January 25, 2021, and currently worked the night shift (10:00 p.m. to	0 660		

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0 660	Continued From page 27 7:00 a.m.). ULP-F's record included a TB history and symptom screen, however is was dated June 7, 2021, six months after hire. ULP-F had one negative TST dated June 7, 2021. ULP-F did not have a second TST. On August 18, 2021, at 2:48 p.m. ULP-A verified the TB symptom screen for ULP-F was completed six months post hire and confirmed the employee did not have a second TST completed. On August 19, 2021, at approximately 10:45 a.m., ULP-A verified the employees' required screenings were likely "an oversight." The owner was also present during the interview, stated "we need to be on that." The licensee's policy, "TB Prevention and Control," effective August 1, 2021, indicated the agency would establish and maintain a TB prevention and control program based on the most current guidelines issued by the Center for Disease Control and Prevention (CDC) and the Minnesota Depart of Health guidelines would be followed. The policy indicated there would be completion of a written TB risk assessment for the agency and annual review and revision as needed. Further, the policy indicated there would be screening of assisted living staff for TB and reports of TB screening would be in the personnel files of assisted living employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 28 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency disaster plan with all required content and failed to post an emergency plan prominently. This had the potential to affect all nine 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	0 680		

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0 680	Continued From page 29 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: During tour upon entrance to the facility on August 17, 2021, at approximately 10:10 a.m., there was no observed signage posted or information regarding the licensee's emergency plan. Except for posting of emergency exits, nothing regarding an emergency preparedness plan was posted at the facility entrance, on any of the two main hallways, near the nursing station, in the dining area or in the living area. During the entrance conference on August 17, 2021, at approximately 10:45 a.m., a request was made to view the licensee's emergency preparedness plan, which was later reviewed by the surveyor. The plan, contained in a three-ringed binder, included an undated, generic policy titled "Emergency Preparedness in Assisted Living, Plans Based on Specific Emergency Situations"; however the plan referenced state statutes and identified a date of January 1, 2016. The plan included a "Hazard Vulnerability Assessment," dated April 23, 2018. The policy contained within provided direction on making an emergency plan and its policies listed various emergency situations (such as heat, several weather emergencies, emergency evaluations, plan activations); however, the procedures spelled out in the plan were generic, lacking specificity to the licensee's site. Additionally, there was a phone calling tree; a document "Communications," with	0 680		

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0 680	Continued From page 30 facility name, address and phone numbers of incident commander staff (undated); a fire safety policy and procedure; a missing resident policy and procedure; and a one-page document addressing steps to be taken to address medical emergency, power outage, tornado, hazardous materials, threat of violence, suspicious person and emergency lookdown. On August 19, 2021, at approximately 10:15 a.m., the surveyor reviewed the emergency preparedness plan and components with unlicensed personnel (ULP)-A, owner and registered nurse (RN)-G. ULP-A verified their plan had not been updated since the date "on the assessment". The licensee's plan lacked the following required content: -current, all-hazards approach facility assessment -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations. -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents' -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; -arrangement with other faculties (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including	0 680		

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0 680	Continued From page 31 documentation of training provided); -annual EP testing requirements. During the interview, ULP-A and owner pressed understanding of there tasks to update and more fully flesh out their current EP plan, and begin by completing a facility assessment. ULP-A verified the current plan did not meet the statutory requirements presently, and stated this would be "an ongoing" process. RN-G added they would be working with their sister facility to develop their emergency plan. The licensee's policy Emergency Preparedness Plan dated January 15, 2018, indicated the licensee would have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency or disaster that disrupts services. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history,	0 730		

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0 730	Continued From page 32 allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the client record included documentation of significant	0 730		

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	28686	A. BUILDING: _____ B. WING _____	08/19/2021

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0 730	Continued From page 33 changes in the residents status and action taken in response to the needs of the resident after a change in condition, for one of one resident (R1) with record reviewed. 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was hospitalized on August 6, 2021, after sustaining a fall with injury. R1's record lacked documentation of significant changes in R1's condition and actions taken in response to the needs of R1. R1's most recent nursing assessment dated July 7, 2021, completed by registered nurse (RN)-B identified the resident was high risk for falls and required fall risk safety checks. R1's service plan dated August 5, 2021, indicated R1 was independent with transfers, but needed physical assist of one for ambulation. A Resident Incident Report dated August 6, 2021, at 6:30 p.m. indicated R1 sustained an unwitnessed fall in the "Common Area: Building Grounds." The incident report included, "Were there apparent injuries?" and, "Yes, abrasion, hit head, pain." The report identified R1 reported: to have lost balance, fell and lost consciousness, and had pain on right side of face pain in neck and pain in right knee. The report identified R1	0 730		

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0 730	Continued From page 34	0 730		

was observed by unlicensed personnel (ULP)-A at that time as having dried blood on right side of face. The comments section of the Resident Incident Report included, "[R1's name] fell while walking up the hill to Hyatt House. [R1] was dropped off at the bottom of the hill after a dispute with his girlfriend." The Incident Report "Incident Investigation" section was completed by employee A and the follow up included "Documentation in the resident service notes, Physician evaluation." Employee A called 911 and R1 was taken to hospital on August 6, 2021, at 6:45 p.m. R1's record lacked documentation of follow up by a RN.

R1's record included an After Visit Summary from the hospital visit August 6, 2021. The summary listed the reason for visit was "Fall Injury" and diagnoses included, "Fall, facial abrasion, contusion of right knee." R1 received a CT scan of the head and x-ray of right knee. The discharge instructions directed to: use ice for swelling and Tylenol as needed; call primary medical doctor Monday for follow up visit that week, for re-examination of the knee if continued pain and swelling.

A Progress Note completed by ULP-C dated August 10, 2021, at 8:48 am included, "Resident was [sic] C/O [complaining of] knee pain and resident told staff he has not been the same. Resident has problems with his head."

The client record lacked any RN entries from August 6, 2021, through August 17, 2021.

On August 18, 2021 at 9:00 a.m. R1 was observed seated in a manual wheelchair and stated he "gets off balance" when trying to walk and that he needed both knees replaced. R1

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0 730	Continued From page 35 confirmed the RN did not re-assess him after the fall and hospitalization. R1 indicated he had a concussion and bruises from the fall on August 6, 2021. On August 18, 2021, at 3:30 p.m. RN-B confirmed she was aware of R1's fall but she had not re-assessed R1 post fall and post hospitalization. RN-B also verified there were no new interventions or changes to care plan to address fall risk and prevent future falls. The licensee's Reporting, Documenting and Reviewing Incidents Involving Resident policy dated July 31, 2021, indicated staff would immediately contact the RN and the RN would review the incident within 24 hours, and the RN would then discuss findings of the investigation with the resident and staff and implement changes to the service plan as indicated. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated August 1, 2021, indicated the RN would re-assess the resident if there was a change in condition and update the service plan as necessary based on the resident's needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working	0 770		

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0 770	Continued From page 36	0 770		

or inspected and approved water and septic systems must be in place;
(2) the location must be publicly accessible to fire department services and emergency medical services;
(3) the location's topography must provide sufficient natural drainage and is not subject to flooding;
(4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and
(5) the location must include space for outdoor activities for residents.

This MN Requirement is not met as evidenced by:
Based on observations and interview, the facility failed to provide space for outdoor activities for residents. This had the potential to directly affect the well-being of all nine residents.

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:

On August 17, 2021, at 12:45 pm survey staff began the tour. Staff toured the exterior of the building and observed that there was not a designated outdoor activities area for residents. Further interview with unlicensed personnel (ULP)-B she explained the designated space was at the main entrance of the building under the

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0 770	Continued From page 37 vestibule. Staff also observed during the tour, residents gathered under at the paved front entrance vestibule which leads to a sloped sidewalk then street parking. The licensee lacked a policy related to outdoor activity space. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 770		
0 780 SS=I	144G.45 Subd. 2 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	0 780		

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0 780	Continued From page 38 existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to comply with the State Fire Code. This had the potential to affect all nine residents receiving assisted living services and all staff. This resulted in an immediate correction order. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On August 17, 2021, at 12:45 pm survey staff began the tour. 1. The integrity of the occupancy separation of abandoned building is unknown and/or compromised. a. A 1 ½ - hour fire rated door separates assisted living facility from the abandoned building. One leaf panel of the fire door does not self-close. Door closer device was not working. b.The fire protection riser and fire alarm system panel are located in the abandoned building in an unprotected location. 2. In interview with employee A (unlicensed personnel/housing manager), she explained that the lower level of assisted living facility is not currently being used as living quarters. Lower level of building is accessible by stairway from main level of facility.	0 780		

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0 780	Continued From page 39 a. Hard wired smoke detector removed from bracket in hall corridor. b. Two smoke alarms were not illuminated indicating that the alarms were not working properly. c. Enclosed area under exit stairs used for storage, creating a potential fire hazard. 3. Exit door discharging out onto abandoned driveway does not auto-latch after opening. 4. Kitchen ANSUL system not inspected biannually, dates of most recent inspections are 02/05/2021 and 02/17/2021. Staff observations noted during tour: Two types of sprinklers were installed on the ceiling in the main corridor hallway, this does not comply with Chapter 8 of NFPA 13. The licensee's policies related to environmental health concerns was requested but none provided. R1's "Hyatt House Lease Agreement" dated July 13, 2020, and signed by R1 and unlicensed personnel (ULP)-A under V. (B) on page seven, indicated Hyatt House would maintain the residents room in a fit and habitable condition, would maintain all common areas in a clean and structurally safe condition and would maintain all equipment, appliances and fixtures, and all electrical, plumbing, heating, ventilating and air conditioning equipment in good and safe working order and condition. No further information was provided. Time period to correct: Immediately	0 780		

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0 800	Continued From page 40	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) 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 observations and staff interview, facility failed to provide and maintain the building physical environment including walls, floors, ceiling, furnishings, equipment including air handling system in a continuous state of good repair and operation for health, comfort, and well-being of residents in accordance with a maintenance and repair program. This has the potential to directly affect all residents and staff. 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: On August 17, 2021, at 12:45 pm, survey staff began the facility tour. 1. The building air handling system is not functioning based on: a. An interview with unlicensed personnel (ULP)-A, she explained the building air handling	0 800		

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0 800	Continued From page 41 system has not been working since last winter (as she recalled) and that space heaters and portable air conditioning units have been used. b. The front entry door and kitchen exterior door were observed in an open position for outside air. c. Space heaters were found located in the lower day room next to an exit door, in the dining room and in resident room #4. d. Portable air conditioning units were utilized in resident bedrooms. e. Due to the air handling unit not functioning, the exterior doors were held in the open position, flies were observed inside the building along with sticky fly traps hanging from the ceiling in multiple locations with dead flies. 2. Exhaust fan in resident room #7 has no cover and not functioning order. 3. Furnishings, ceiling, lighting, and flooring were not in continuous state of good repair and maintenance: a. Carpeting was stained throughout building and resident rooms. b. Ceiling tiles were stained from leakage throughout building and resident rooms. c. Coved base near tubs in rooms 1 & 6 broken and chipped creating potential for injuries on foot. d. Light bulbs were out in the mop room, upper day room, and shared restrooms. e. Resident rooms 2 & 7 were missing toilet paper holders. 4. Building roof and day room wall conditions are structurally compromised due to leakages throughout the building: a. Ceiling tiles had water stains consistently throughout the building including the lower day room, and bedrooms. One tile in corner of the lower day room was missing, and one sagging heavily. Interview with facility house manager, she stated that it's not uncommon to have someone	0 800		

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0 800	Continued From page 42 come to repair the roof every year and leaking roof has been an ongoing problem in many areas of the building. b. Wall of the lower day room on the exit door side is damaged. This is transparent based on findings of two plastic 1-gallon rectangular containers placed on windowsills to catch leaking water and windowsills heaving from absorbing water from leaks. Staff tour of the exterior of the building noted that roof downspout was broken and lying on ground outside the lower day room and appeared to contribute to the unsound condition of the wall. c. Water-stained roll of construction drawings that were moldy found in lower day room and the room smelled musty/moldy. 5. Plumbing deficiency findings: a. The water softener was uncovered subject to contaminating the building water supply system. b. The hand-held shower spray was broken in the shared bathroom for resident rooms 8/9. Staff observations noted during tour: a. Abandoned water heater/piping in the storage room next to the laundry room. Interview with facility housing manager indicated that the piping of this abandoned system is still connected to the building water system. The system should be disconnected and capped off accordingly by a licensed plumbing contractor to avoid and minimize stagnant water and prevent legionella growth. b. Light fixtures contained accumulation of dead of insects throughout the building and resident rooms. Insect sticky strip hanging with flies throughout the building. A mouse ran across the kitchen floor while touring. c. Exhaust fans in resident bathrooms and public restroom were layered with collection of	0 800		

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0 800	Continued From page 43 dust. d. No toilet paper in the shared bathroom for rooms 8/9, leading to potential spreading of pathogens (infection control concerns). e. Furniture, light fixtures, bathroom floors, and ceiling tiles throughout the facility were dirty and/or dusty. The licensee's policies related to environmental health concerns was requested but none provided. R1's "Hyatt House Lease Agreement" dated July 13, 2020, and signed by R1 and ULP-A under V. (B) on page seven, indicated Hyatt House would maintain the residents room in a fit and habitable condition, would maintain all common areas in a clean and structurally safe condition and would maintain all equipment, appliances and fixtures, and all electrical, plumbing, heating, ventilating and air conditioning equipment in good and safe working order and condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=I	144G.45 Subd. 2 Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 44 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 the review of the emergency plan provided for the facility and interview with housing manager, the facility failed to provide the required documentation on fire safety and evacuation plans and the required training and records. This has the potential to directly affect safety of all nine residents and all staff. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was	0 810		

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0 810	Continued From page 45 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: On August 17, 2021, at 12:45 pm, survey staff began the facility tour. The facility emergency documentation failed to provide: 1. Details of evacuation routes for fire and emergency safety on their emergency exit building plans. 2. Documentation on specific procedures for employee fire drill actions, fire protection procedures necessary for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during evacuation especially for residents who are wheelchair bound and needing assistance during evacuation. 3. The required minimum total number of six employee evacuation drills. The facility document indicates twice a year. 4. The required records on training of employees on fire safety and evacuation. 5. The required records on training of residents who are capable of assisting their own evacuation on proper actions to take in the event of a fire for their safety including movement, evacuation, or relocation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 820 SS=I	144G.45 Subd. 2 Fire protection and physical environment	0 820		

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0 820	Continued From page 46 (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observations and staff interview, the licensee failed to provide and maintain the building electrical system in a continuous state of good repair and operation for health, comfort, and well-being of residents. In addition, the licensee failed to provide and maintain the building smoke alarms in a continuous state of good repair and operation for health, comfort, and well-being of residents. This has the potential to directly affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: BUILDING ELECTRICAL SYSTEM On August 17, 2021, at 12:45 p.m., survey staff	0 820		

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	28686	A. BUILDING: _____ B. WING _____	08/19/2021

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0 820	Continued From page 47 began the facility tour. In the lower day room, an open electrical wire was observed extending out of an electrical outlet next to the fireplace. In an interview with unlicensed personnel (ULP)-A indicated she did not know there was an open electrical wire in this location. BUILDING SMOKE ALARMS On August 17, 2021, at 12:45 p.m., survey staff began the facility tour. In resident room one, a smoke alarm was not provided, there was an empty smoke alarm bracket on the ceiling. In an interview with ULP-A indicated, she did not know the smoke alarm was missing. Smoke alarm green lights were not illuminated indicating that the smoke alarms were working property in resident rooms 4, 6, 7, 9 and 10. In an interview with employee A indicated she thought the smoke alarms were battery operated and did not know the green lights were not illuminated. Smoke alarms were not provided outside the sleeping areas in the immediate vicinity of bedrooms for resident rooms eight, nine, ten and eleven. TIME PERIOD TO CORRECT-IMMEDIATE	0 820		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observations and staff interview, facility failed to comply with applicable state and local governing laws. This has the potential to directly affect all nine residents and all staff.	0 830		

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0 830	Continued From page 48 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: On August 17, 2021, at 12:45 pm survey staff began the tour. Fire extinguishers were not provided on lower level of building. Staff observations noted during tour: a. In laundry room, the clothes dryer vent duct runs through wood cabinets and then out a window. b. Several portable and window air conditioning units obstruct egress windows in resident rooms, these rooms are provided with automatic fire sprinklers. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided	0 900		

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0 900	Continued From page 49 directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute an Assisted Living contract to include all required content for nine of nine 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	0 900		

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0 900	Continued From page 50 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: R1's record lacked a written contract with the following required content: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon	0 900		

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0 900	Continued From page 51 agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. On August 18, 2021, at 3:40 p.m. registered nurse (RN)-B confirmed a contract had not been developed or implemented for the licensee's nine current client. The licensee lacked a policy related to Assisted Living Contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=F	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for nine of nine residents.	0 910		

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0 910	Continued From page 52 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: R1's record lacked a written contract with the following required content: (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. On August 18, 2021, at 3:45 p.m. registered nurse (RN)-B confirmed a contract had not been developed or implemented for the licensee's nine residents. The licensee lacked a policy related to Assisted Living Contract contents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		

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01320 SS=D	144G.60 Subd. 4 Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (ULP-F) completed training and competency evaluations in all required training topics. 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01320		

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01320	Continued From page 54 Unlicensed personnel (ULP)-F had a hire date of January 25, 2021, and worked the night shift 10:00 p.m. to 7:00 a.m. Employee F's record lacked documentation the employee had completed training and competency testing in topics listed in 144G.61 subdivision 2. On August 18, 2021, at 4:00 p.m. registered nurse (RN)-B verified ULP-F record lacked evidence of completed training and competency testing in topics listed in 144G.61 subdivision 2. The licensee's "Staff Orientation and Education" policy dated July 1, 2017, lacked identification of required training topics in 144G.61, and referred to the old 144A statutes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01320		
01330 SS=D	144G.60 Subd. 4 Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or	01330		

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01330	Continued From page 55 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (ULP-F) completed training and competency evaluations in all required training topics. 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Unlicensed personnel (ULP)-F had a hire date of January 25, 2021, and worked the night shift 10:00 p.m. to 7:00 a.m. ULP-F's record lacked documentation the employee had successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform. On August 18, 2021, at 4:00 p.m., registered nurse (RN)-B verified ULP-F record lacked evidence of completed training and competency testing in all required training topics.	01330		

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01330	Continued From page 56 The licensee's "Staff Orientation and Education" policy dated July 1, 2017, lacked identification of required training topics in 144G.61, and referred to the old 144A statutes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01330		
01430 SS=D	144G.62 Subd. 3 Supervision of staff (a) Staff who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be supervised periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. The supervision of the unlicensed personnel must be done by staff of the facility having the authority, skills, and ability to provide the supervision of unlicensed personnel and who can implement changes as needed, and train staff. (b) Supervision includes direct observation of unlicensed personnel while the unlicensed personnel are providing the services and may also include indirect methods of gaining input such as gathering feedback from the resident. Supervisory review of staff must be provided at a frequency based on the staff person's competency and performance. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of direct	01430		

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01430	Continued From page 57 supervision of unlicensed personnel (ULP) for one of two employees (ULP-F) with employee records reviewed. 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F had a hire date of January 25, 2021, and worked the night shift 10:00 p.m. to 7:00 a.m. ULP-F's employee record lacked documentation of direct supervision to verify that the work was being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On August 18, 2021, at 4:00 p.m. registered nurse (RN)-B verified ULP-F's record lacked documentation of direct supervision. The licensee's ""Supervision" policy dated December 1, 2014, indicated home health aides providing delegated services to home health residents would be supervised to assure that the work was being performed competently and to identify problems and solutions to address issues related to the employee's ability to provide the services to residents of Hyatt House. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01430		

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

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01470	Continued From page 59 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for two of two employees (ULP-D, ULP-F) with employee records reviewed. 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: ULP-D and ULP-F's employee records lacked evidence to indicate the employees had received	01470		

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01470	Continued From page 60 orientation to include the following topics: - an overview of Assisted Living laws 144G. - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services - a review of the types of assisted living services the employee will be providing and the facility's category of licensure ULP-D hire date was October 22, 2020. ULP-F hire date was January 25, 2021. Both employee records lacked the above required content. On August 18, 2021, at 4:00 p.m. registered nurse (RN)-B confirmed all employees had not received the above noted required training. The licensee's "Assisted Living & Assisted Living with Memory Care Orientation - All Staff" policy,	01470		

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01470	Continued From page 61 dated June 1, 2021, noted all employees must complete orientation to include: - overview of Minnesota's assisted living law - introduction and review of the licensee's policies and procedures related to the provision of assisted living services - emergency and disaster training - the assisted living bill of rights - principles of person-centered planning and service delivery - types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and the licensee's scope of licensure - consumer advocacy services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure required dementia care training for two of two employees (ULP-D, ULP-F) with employee records reviewed. 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	01490		

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01490	Continued From page 62 client'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 clients 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 August 17, 2021, at approximately 11:03 a.m. unlicensed personnel (ULP)-A stated they do not have a special dementia care unit, they don't advertise or accept residents with dementia. ULP-A stated all direct care staff were required to get some dementia training and followed the state guidelines. ULP-A stated she could not recall the required number of training hours. ULP-D was hired October 22, 2020, to provide assisted living services to the licensee's residents. On August 17, 2021, at approximately 2:15 p.m., employee D was observed to assist R2 with personal cares and transfers. ULP-D's employee record and training transcripts lacked evidence the employee had any dementia-care related training. ULP-F was hired January 25, 2021, to provide assisted living services to the licensee's residents. On August 18, 2021, at approximately 8:53 a.m., ULP-F was assisting a resident and observed removing garbage from the R2's room. ULP-F's employee record and training transcripts lacked evidence the employee had any dementia-care related training. On August 18, 2021, at 3:30 p.m. registered nurse (RN)-B confirmed the employee records lacked evidence of any dementia care training.	01490		

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01490	Continued From page 63 The licensee's Staff Orientation and Education policy dated July 1, 2017, indicated, "Hyatt House does provide training related to Alzheimer's/dementia. Staff providing or supervising care to residents with Alzheimer's/dementia will receive education prior to providing care." No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01490		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a	01620		

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01620	Continued From page 64 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive re-assessment following a change of condition (hospitalization) for one of two residents (R1) with records reviewed. 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was hospitalized on August 6, 2021, after sustaining a fall with injury. R1's record lacked a re-assessment by the RN to determine causal factors and consider new care plan interventions for prevention of future risk for falls. R1 was admitted for assisted living services on July 13, 2020, with diagnoses including but not limited to schizoaffective disorder, heart failure, generalized anxiety disorder and type II diabetes. A "Resident Incident Report" dated August 6, 2021, at 6:30 p.m. indicated R1 had sustained an unwitnessed fall in the "Common Area: Building Grounds". The incident report included "Were there apparent injuries?" and the answer was "Yes, abrasion, hit head, pain". The resident	01620		

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reported he had lost his balance, fell and lost consciousness, had pain on right side of face and pain in his neck and right knee. The resident was observed by unlicensed personnel (ULP)-A at that time as having dried blood on right side of face. The comments section of the incident report included "[R1's name] fell while walking up the hill to Hyatt House. He was dropped off at the bottom of the hill after a dispute with his girlfriend". The Incident Report "Incident Investigation" was completed by ULP-A and the follow up included "Documentation in the resident service notes, Physician evaluation." R1's record lacked documentation of follow up by the RN.

ULP-A called 911 and R1 was taken to hospital on August 6, 2021, at 6:45 p.m.

Progress Notes dated August 6, 2021 through August 17, 2021, lacked any entry by a RN. Progress Notes dated August 10, 2021, at 8:48 am included "Resident was C/O knee pain and resident told staff he has not been the same. Resident has problems with his head", writer was ULP-C.

R1's record included an "After Visit Summary" dated August 6, 2021. This document listed the reason for visit as "Fall Injury" and diagnoses included "Fall, facial abrasion, contusion of right knee". R1 received a CT of the head and right knee X-ray. The discharge instructions directed to use ice for swelling and Tylenol as needed. Call primary MD Monday for follow up visit this week for re-examination of the knee if continued pain and swelling.

On August 18, 2021, at 3:30 p.m. RN-B confirmed she was aware of R1's fall but she had not re-assessed R1 post fall and post

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hospitalization and verified there were no new interventions or changes to care plan to address fall risk and prevent future falls.

On August 18, 2021 at 9:00 a.m. R1 was observed seated in a manual wheelchair and stated he gets off balance when trying to walk and that he needs both knees replaced. R1 confirmed the RN did not re-assess him after the fall and hospitalization. R1 indicated he had a concussion and bruises from the fall on August 6, 2021.

R1's most recent nursing assessment dated July 7, 2021, completed by RN-B indicated high risk for falls and requires fall risk safety checks. R1's service plan dated August 5, 2021, indicated R1 was independent with transfers but needed physical assist of one for ambulation. The service plan was not updated post fall and hospitalization.

The licensee's "Initial and On-Going Nursing Assessment of Residents" policy dated August 1, 2021, indicated the RN would re-assess the resident if there was a change in condition and update the service plan as necessary based on the resident's needs.

The licensee's "Reporting, Documenting and Reviewing Incidents Involving Resident" policy dated July 31, 2021, indicated staff would immediately contact the RN and the RN would review the incident with in 24 hours, and the RN would then discuss findings of the investigation with the resident and staff and implement changes to the service plan as indicated.

No further information was provided.

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01620	Continued From page 67 TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication re-assessments for one of two residents (R1) with records reviewed. 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked documentation of an annual medication re-assessment. The most recent medication assessment was dated July 14, 2020. On August 18, 2021, at 3:50 p.m. RN-B confirmed she had not completed the annual medication re-assessment that was due for R1 in	01710		

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01710	Continued From page 68 July, 2021. The licensee's "Assessment for Medication & Treatment Management Program" dated March 10, 2017, indicated medication re-assessments would occur annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01710		
01740 SS=D	144G.71 Subd. 6 Administration of medication Medications may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (ULP-F) had been trained and competency tested prior to delegating administering medications. 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01740		

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01740	Continued From page 69 Unlicensed personnel (ULP)-F had a hire date of January 25, 2021, and was working the night shift (10:00 p.m. to 7:00 a.m.) Employee F's record lacked documentation the employee had been trained and competency tested prior to being delegated medication administration. On August 18, 2021, registered nurse (RN)-B confirmed ULP-F did administer medications to residents and verified the employee record lacked documentation the employee had been trained and competency tested prior to being delegated medication administration. RN-B stated she would suspend his giving medications until properly being trained and competency tested. The licensee's Medication Administration policy dated November 29, 2017, indicated the RN may delegate medication administration to unlicensed staff only after the staff passes a competency evaluation with respect to all medication routes to be administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01740		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760		

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01760	Continued From page 70 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the residents medication management plan included resident specific instructions related to priming of insulin pens prior to use for two of two residents (R1, R2) and dating time sensitive medications when opened for R1. 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: R1's diagnoses included, but were not limited to, diabetes with diabetic neuropathy. R1's service plan, dated August 8, 2021, indicated the resident received insulin four times daily, to be provided by the resident assistant (unlicensed personnel). R1's prescriber's order, August 7, 2021, included the following insulin and diabetic injection medications: -Novolog (insulin) Flexpen 100 U/ml, (units per milliliter) inject 36 units SQ (subcutaneously) 3 times daily with meals 08:00, 12:00, 17:00;	01760		

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01760	Continued From page 71 -Levemir (insulin) FlexTouch (pen) 100 U/ML, inject 68 units SQ twice daily 08:00, 20:00; -Ozempic (medication used to treat type 2 diabetes) 4 mg/3 ml, every Wednesday; inject 0.75 mg (1 mg) SQ once weekly at 08:00. On August 18, 2021, at approximately 7:47 a.m., after obtaining a blood sugar measurement, unlicensed personnel (ULP)-C asked R1 if he was ready for his morning medications. After answering yes, (ULP)-C went to the nursing station/medication storage area then washed her hands. After setting up numerous oral medications, (ULP)-C gathered three insulin pens from the refrigerator, checked expiration dates, then set each pen up with a needle for injection. (ULP)-C then dialed and set the dosage for Ozempic to 0.5 mg. The label on Ozempic medication had no opened date; there was a pharmacy label with "date opened" and area to write the date. (ULP)-C dialed 36 units on the Novolog insulin pen; the Novolog had date opened "8/15" written on the label. (ULP)-C did not prime the Novolog insulin pen. And lastly, (ULP)-C dialed 68 units on the Levemir pen; there was a label, but no opened date written on it. (ULP)-C also did not prime the Levemir medication pen. Following the administration of the insulin and Ozempic medication to R1 at approximately 7:48 a.m. (ULP)-C washed her hands. (ULP)-C verified the Ozempic and Levemir pens had no "opened" date on the label, and stated "whoever opened these pens obviously did not date them, adding "we're supposed to." (ULP)-C also confirmed she did not prime any of the insulin or Ozempic and state "I didn't know I had to." (ULP)-C stated she primes the pens "the first	01760		

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01760	Continued From page 72 time we open them" but stated, "I honestly never heard that" having to prime the pens with each use, adding "I could be wrong though." R2's diagnoses included, but were not limited to hypertension, diabetes with poly neuropathy, peripheral vascular disease and obesity. R2's Medication Treatment Therapy Management Plan dated September 29, 2020, indicated the resident received medication management services. R2's prescriber orders, dated August 18, 2021, included the following injection medications: -Novolog mix 70/30 Flexpen insulin, 100 Unit/Ml suspension; inject 50 units before breakfast; -Ozempic 1 mg/dose (4 mg/ml) every Wednesday; inject 0.75 mg (1 Mg) SQ once every 7 days. On August 18, 2021, at approximately 8:17 a.m., (ULP)-C began medication set up for R2, which also included use of an insulin pen and a medication injected with a pen. (ULP)-C place a new needle on and then dialed up 48 units of Novolog and did not prime the pen. Then (ULP)-C placed a needle on the Ozempic medication, dialed up the dosage (0.75 ML) and did not prime the pen. Following administration of the insulin and Ozempic medications in R2's room, (ULP)-C returned the medications to the storage area and washed her hands. At approximately 8:33 a.m., (ULP)-C verified she did not prime the insulin or Ozempic for R2 prior to the administration of those medications. On August 18, 2021, at approximately 3:54 p.m. registered nurse (RN)-B stated the priming of insulin pens prior to administration was	01760		

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addressed in training, and priming of the pens is a part of the skills competency. RN-B stated the insulin pens "should have been primed" each time prior to administration. RN-B also stated she had not thought about dating medications that "were scheduled" because they are used up quickly, but acknowledged if the resident goes away for a time, for example to the hospital, the resident may not use their own insulin for a while. RN-B stated she would expect eye drops and various liquid medications to be dated, and thought it would be useful to date insulin and "especially" as needed inhalers and also said it would be "good practice." RN-B stated she did not know if they had a policy that addressed the dating of medications.

The licensee's policy "Insulin Pen Medication Protocol with a Reusable Pen," undated, directed to prime the insulin pen following manufacturer's instructions. A policy regarding dating of time-sensitive medications was requested, but none was provided.

Novolog Insulin FlexPen manufacturer's guide, dated May 2016, directed to prime the pan with 2 Units and make sure a drop appears, prior to each use before selecting a dose. The guide also indicated to store opened FlexPen out of the refrigerator below 86 deg. F for up to 28 days.

Levemir FlexTouch insulin pen manufacturer's guide, dated June 2016, directed to prime the pen with 2 Units and make sure a drop appears, prior to each use before selecting a dose. The guide also indicated to store opened FlexTouch pen out of the refrigerator below 30 deg. Celsius (86 deg. F) for up to 42 days.

Ozempic manufacturer's guide, dated May 2021,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 74 indicated after first use of the Ozempic pen, the pan can be stored for 56 days at controlled room temperatures (59 - 86 degrees Fahrenheit) or in a refrigerator (36 to 46 Deg. F.) The guide also directed to check the Ozempic flow (prime the pen) only before the first injection with each new pen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permit only authorized personnel had access. 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:	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28686	A. BUILDING: _____ B. WING _____	08/19/2021

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01880	Continued From page 75 On August 17, 2021, at 10:15 a.m. medications were observed unsecured in one of three cupboards located in the medication hallway. The cupboard metal latch was broken. A plastic bin in the unsecured cupboard contained, Milk of Magnesia, Tums, Citrucel, Equate liquid antacid and Equate anti-diarrhea. On August 17, 2021, at 10:16 a.m. unlicensed personnel (ULP)-C confirmed the medications were not secured and verified the latch to the cupboard was broken. ULP-C also verified the two other locked medication cupboards could easily be opened with a screw driver, and confirmed medication storage cupboards were not substantially constructed. On August 17, 2021, at 10:40 a.m. the medication cabinet keys were observed on the counter directly under the medication cupboards and staff were not present in the area. In addition, the door in the medication hallway was observed to be propped open all day to the outside. On August 18, 2021, at 8:07 a.m. observation revealed a large black safe in the housing managers office containing multiple medications with the safe door wide open. ULP-A confirmed the large black safe containing multiple medications is never locked as the safe "does not lock", ULP-A confirmed the safe door in her office is always left open and that her office door locks but she never closes the office door either. ULP-A confirmed clients could access the medications if she was not present in the office. The licensee's "Storage/Control of Medications" policy dated March 10, 2017, indicated all prescription drugs would be securely locked in substantially constructed compartments and only	01880		

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01880	Continued From page 76 authorized personnel would have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must	01940		

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01940	Continued From page 77 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of two residents (R2) with blood glucose monitoring. 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included, but were not limited to, hypertension, diabetes with poly neuropathy, peripheral vascular disease and obesity. R2's service plan, dated August 8, 2021, lacked any mention the resident received the treatment service of blood sugar monitoring. R2's "Medication Treatment Therapy Management Plan" dated September 29, 2020, also lacked inclusion of the treatment to monitor blood sugar. On August 18, 2020, at approximately 8:24 a.m., unlicensed personnel (ULP)-B and ULP-H entered R2's room to administer medications and deliver a breakfast tray. ULP-B was observed to obtain R2's blood sugar, which was 102 mg/dl (milligrams per deciliter); a reading within normal limits. At approximately 10:22 a.m., ULP-B stated	01940		

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01940	Continued From page 78 R2 had his blood sugar taken every time before he gets insulin and the results were recorded in the electronic chart. ULP-B stated she did not know if parameters were in the chart, but there was a guide somewhere if the blood sugars were too high or too low, and then I would call the nurse." R2's Service plan/Medication Treatment therapy Management Plan lacked the following content: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating tot he treatment or therapy administration; -identification of the treatment or therapy that will be delegated to unlicensed personnel; -procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and -any resident-specific requirements relating to documention of treatment and therapy received' verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On August 18, 2021, at approximately 3:46 p.m., registered nurse (RN)-B acknowledged that neither R2's service plan nor medication/treatment management plan included the treatment to monitor blood sugar. RN-B stated she did not know why it was not included and said the identification of blood glucose testing "should be part of the plan." RN-B also acknowledged the service and treatment management plan was incomplete and lacked the required items.	01940		

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01940	Continued From page 79 The licensee's Service Plan for Medication & Treatment Management policy revised March 10, 2017, indicated the licensee would prepare and document a Medication & Treatment Management Plan as part of the service plan for each client receiving medication and treatment management services. The policy further indicated the plan would include the specific components listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
02240 SS=F	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."	02240		

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02240	Continued From page 80 (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all residents had received and had written acknowledgement of receipt of the new Assisted Living Bill of Rights and information about how to make a complaint. This had the potential to affect all nine assisted living residents. 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	02240		

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02240	Continued From page 81 failure that has affected or has potential to affect a large portion or all of the clients). The findings include: R1 had an admission date of July 13, 2020. R1's record lacked evidence the resident/representative received and had written acknowledgement of receipt of the new Assisted Living Bill of Rights or information about how to make a complaint. R2 had an admission date of September 21, 2020. R2's record lacked evidence the resident/representative received and had written acknowledgement of receipt of the new Assisted Living Bill of Rights or information about how to make a complaint. On August 18, 2021, at approximately 3:42 p.m., registered nurse (RN)-B verified none of the resident had received a copy of the new assisted living bill of rights or information about how to register a complaint. RN-B stated they have not gone to each of the residents to address this. RN-B stated this would be the case for all nine, current residents of the facility. A policy regarding providing residents/representatives the bill of rights and information on complaints was requested from the licensee, but none was provided. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02240		

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02310	Continued From page 82	02310		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R2) who utilized bed rails, with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included, but were not limited to hypertension, diabetes with poly neuropathy, peripheral vascular disease and obesity. R2's Vulnerability, Safety & Risk assessment dated August 17, 2021, indicated the resident: did not ambulate independently and uses a wheel chair; was unable to move lower extremities and poor movement in upper extremities and has poor endurance and strength. The assessment lacked any mention R2 had or used bed side rails.	02310		

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02310	Continued From page 83 On August 17, 2021, at approximately 1:28 p.m., R2 was observed in his room, seated in an electric wheel chair and next to the wheel chair was R2's bed, equipped with bilateral side rails. The rails were approximately three feet wide by one and one-half feet in height. The rail mid section had four vertical bars (about 1 1/2 feet in height) and were flanked by two additional vertical bars and each side, which were about one foot in height. There were eight vertical bars in total, each spaced about four inches apart. The rails could be raised and lowered. When the mattress was lifted, it revealed the rails were connected by two bars. The rails were not bolted or otherwise secured to the bed frame; the weight of the mattress is how the rails were stabilized. When the surveyor grasped the rail, it could be moved to and fro, to a position nearly level with the mattress. There was no gap observed between the rail and mattress. The rail closest to R2's door was observed presently lowered. R2 was asked about the side rails and stated he used them to reposition himself once in the bed, and would also grab onto it when staff assisted him to sit up at the side of bed, when getting out of bed. R2 said he was unable to stand up by himself and did not use the rail for balance. R2 also said when the rail was put up, it did not always stay in place and would just fall down. The resident also verified the rail "was very wobbly" and could easily be moved. R2's record lacked evidence a bed rail assessment had been completed and an explanation of the risk and benefits of the use of bed rails had been provided to the resident or the resident's representative.	02310		

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02310	Continued From page 84 On August 18, 2021, at approximately 10:37 a.m., in the presence of the surveyor, unlicensed personnel (ULP)-C measured R2's side rails: 32" in width; 18 1/2" in height (in the mid section), and the shorter end sections rails were 12" in height. The rail had a total of 8 vertical bars, each measured 4 1/2" apart. ULP-C also confirmed the rails could easily be moved back and forth, and were not tightly secured to the bed frame. ULP-C stated she did not see R2 use the rails, that the resident was not able to stand by himself and likely did not use it to maintain his balance. ULP-C stated it was likely the resident used the rail to move himself when in bed. On August 18, 2021, at approximately 3:43 p.m., registered nurse (RN)-B stated she "did not think" a bed rail assessment was completed for R2. RN-B stated the bed ordered by the doctor for the resident was for fall prevention and to allow resident to be able to roll side to side. RN-B expressed understanding of what should be in the bed rail assessment and that there should be a statement of risk versus benefits provided and acknowledged by the resident or representative. RN-B verified these had not been completed for R2. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also	02310		

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02310	Continued From page 85 identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." A policy regarding assessment and use of side rails was requested, but none was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02380 SS=C	144G.91 Subd. 10 Individual autonomy Residents have the right to individual autonomy, initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all nine clients in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the client and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent	02380		

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02380	Continued From page 86 a systemic failure that has affected or has potential to affect a large portion or all of the clients). The finding include: On August 17, 2021, at approximately 10:10 a.m. upon arriving at the establishment, an observation outside the front entrance and inside the front entrance revealed there was no posting for electronic monitoring devices. On August 17, 2021, at 10:20 a.m. a camera labeled "Drop Cam" was observed in the hall by the nursing office. On August 17, 2021, at 10:25 a.m., unlicensed personnel (ULP)-A stated the door we had entered was the main door utilized and confirmed no posting was available related to the statutory language for electronic monitoring. The licensee's "Electronic Monitoring" policy, undated, indicated the licensee must post a sign at the entrance accessible to visitors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02380		

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

Type: Full
Date: *08/17/21*
Time: 10:18:00
Report: 7930211140

Food and Beverage Establishment Inspection Report

Location:
Hyatt House
231 Washington Street
Holdingford, MN56340
Stearns County, 73

Establishment Info:
ID #: N001233
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Hyatt House of Holdingford
Phone #: 320-746-9902
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

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

THE DISHWASHER FINAL RINSE CYCLE MEASURED 0PPM CHLORINE. REPAIR AND SANITIZE DISHES IN THREE COMPARTMENT SINK UNTIL REPAIRED.

Comply By: 08/17/21

2-100 Supervision

2-102.11ABCQ ** Priority 2 **

MN Rule 4626.0030ABCQ The person in charge must be able to demonstrate their knowledge to the inspector of the following factors associated with employee health and the transmission of foodborne disease: symptoms of illness frequently associated with foodborne diseases; food worker illness reporting requirements; and medical conditions requiring exclusion of an employee from work or the restriction of their work duties.

AT THE TIME OF INSPECTION, WHEN ASKED WHAT SYMPTOMS AN EMPLOYEE NEEDS TO BE EXCLUDED FROM WORK WITH, THE PIC (MIRANDA) DID NOT KNOW THE CORRECT SYMPTOMS FOR EXCLUSION (VOMITING AND DIARRHEA).

Comply By: 08/17/21

2-100 Supervision

2-102.11JKLMO ** Priority 2 **

MN Rule 4626.0030JKLMO The person in charge must be able to demonstrate their knowledge to the inspector of the food safety risks within their food operation and the relationship of the following factors to preventing foodborne disease: maintaining the food establishment and equipment in a clean condition and in good repair; procedures for cleaning and sanitizing utensils and food-contact surfaces of equipment; the importance of adequate food service equipment; responsibilities when a HACCP plan is required; proper use of toxic compounds in the establishment; and preventing contamination of the water supply from plumbing cross connections or backflow.

DISHWASHER MEASURED 0PPM CHLORINE DURING INSPECTION AND PIC WAS UNSURE OF WHERE THE TEST KIT WAS TO MEASURE THE SANITIZER LEVEL.

Comply By: 08/17/21

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THE FOLLOWING ARE NOT ANSI CERTIFIED AND NEED TO BE REMOVED: DOMESTIC CROCKPOT, DOMESTIC ELECTRIC GRIDDLE AND DOMESTIC HAMILTON BEACH ROASTER OVEN.

Comply By: 08/17/21

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

A STORAGE CART OF CLEAN PLATES WAS STORED IN THE SPLASH ZONE OF THE HANDWASHING SINK. STORE IN AN AREA WHERE THE PLATES ARE NOT IN A SPLASH ZONE OR NEAR ANY OTHER POTENTIAL CONTAMINATION.

Comply By: 08/17/21

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

AT TIME OF INSPECTION THE DRAIN OF THE HANDWASHING SINK WAS SLOW AND NOT DRAINING PROPERLY. REPAIR.

Comply By: 08/18/21

6-300 Physical Facility Numbers and Capacities

6-303.11C

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

THERE WERE MANY BURNED OUT LIGHT BULBS IN THE LIGHT FIXTURES THROUGHOUT THE KITCHEN. REPLACE BURNED OUT LIGHT BULBS.

Comply By: 08/24/21

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.114AB

MN Rule 4626.1580AB Remove all items unnecessary to the operation or maintenance of the establishment and litter from the premises.

REMOVE THE NON-FUNCTIONING DOMESTIC UPRIGHT WHITE REFRIGERATOR/FREEZER FROM KITCHEN.

Comply By: 08/20/21

Surface and Equipment Sanitizers

Chlorine: = 0PPM at Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: YOGURT--UPRIGHT TWO DOOR COOLER
Violation Issued: No

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

OBSERVED A HOUSEHOLD MOUSE TRAP UNDER THE UPRIGHT FREEZER BUT THERE WAS NO EVIDENCE OF RODENTS OR RODENT DROPPINGS.

NON-PASTEURIZED SHELL EGGS WERE BEING USED IN THE ESTABLISHMENT. PASTEURIZED EGGS ARE REQUIRED WHEN EGGS ARE POOLED TOGETHER AND SERVED TO MORE THAN ONE PERSON AT A TIME.

Food and Beverage Establishment Inspection Report

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 7930211140 of 08/17/21.

Certified Food Protection Manager: ANGELA M. MILHAUSER

Certification Number: FM101220 Expires: 09/19/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
MIRANDA (PIC)

Signed: _____
Inspector ID #7930

651-201-4500
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