DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 25, 2023

Licensee
The Legacy Of Farmington
22300 Denmark Avenue
Farmington, MN 55024

RE: Project Number(s) SL33271015

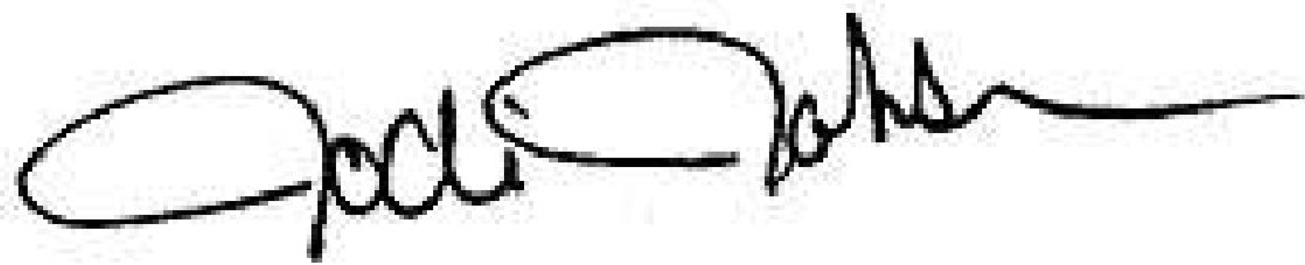
Dear Licensee:

On September 20, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 30, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

PMB

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 28, 2023

Licensee
The Legacy Of Farmington
22300 Denmark Avenue
Farmington, MN 55024

RE: Project Number(s) SL33271015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 30, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH

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 (b), 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 survey:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33271	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	**22300 DENMARK AVENUE FARMINGTON, MN 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33271015 On March 27, 2023, through March 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 74 residents; 66 of whom were receiving services under the provider's Assisted Living with Dementia Care license. 2310: An immediate correction order was issued on March 27, 2023. The immediacy was removed; however, non-compliance remains at a level 3, isolated scope (G). 1290: An immediate correction order was issued on March 29, 2023. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (I).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (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 ensure service instructions were followed by the licensed practical nurse (LPN)-F for one of one resident (R2) observed with catheter care. 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 neuromuscular dysfunction of the bladder (a condition in which problems with the nervous system affect the bladder and urination) and multiple sclerosis (a potentially disabling disease of the brain and spinal cord).	0 510		

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0 510	Continued From page 2	0 510		

R2's service plan dated January 31, 2023, indicated R2 received catheter care daily.

R2's Service Checkoff List dated March 2023, included a task to provide catheter care at 10:00 a.m. Instructions to staff indicated the following: Empty catheter bag at 10:00 a.m. and 2:00 p.m. Provide catheter care at 10:00 a.m. cleaning the catheter tubing per directions below. Apply gloves, always hold catheter at the insertion site (urinary meatus) with one hand to prevent tension/pulling and potentially dislodging the catheter. With the other hand, wipe the catheter downwards using disposable wipes or a clean cloth and soap and water. Wipe the tubing away from the meatus for approximately four inches of catheter tubing. Use a new wipe or side of cloth for each swipe down the catheter tubing two to four times. Using a clean wipe or cloth, complete peri care by cleaning the meatus gently (vigorous rubbing can lead to irritation and potential infection). Finish peri care by further cleaning around the peri area.

On March 28, 2023, at 10:20 a.m. R2 was observed receiving morning cares and catheter care by LPN-F and unlicensed personnel (ULP)-G. LPN-F asked R2 if he wanted to wear his compression stockings and the resident declined. LPN-F then donned gloves and emptied R2's catheter urinary drainage bag into a graduate container using appropriate infection control technique. Once emptied, LPN-F cleansed the end of the drainage tube and the plastic port prior to inserting the tube into the port. LPN-F then emptied the urine into the toilet, cleansed hands, changed gloves then returned to R2's bedside and proceeded to put on his pants. LPN-F threaded the catheter bag and tubing

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0 510	Continued From page 3 through the leg of one of the pairs of pants before pulling them up. As she started pulling the pants up, R2 advised LPN-F that she needed to clean his catheter. R2 had stated to the surveyor prior to the start of morning cares that he had two recent UTI's (urinary tract infections) that required hospitalization and was not sure why they kept occurring. R2 asked ULP-G to obtain his cleansing wipes from behind his TV, and stated he purchased this brand of wipes because that was what the hospital used. LPN-F took one wipe out of the package and indicated it was the last one. LPN-F then took the wipe and cleansed the tubing on the urinary drainage bag but did not cleanse the actual catheter. R2 then advised LPN-F that it wasn't the tubing on the bag that needed to be cleansed but the actual catheter tubing and around where the tubing entered the body. LPN-F stated there wasn't any more wipes and asked what should she use. R2 then stated to ULP-G there were more wipes in his bathroom, which ULP-G then obtained. LPN-F removed one of the wipes and cleansed the catheter but did not cleanse around the meatus of the penis where the catheter entered the body. LPN-F then reached around R2's shoulder and started to sit R2 up in bed so they could use the standing lift to transfer him into his electric wheelchair. R2 directed LPN-F to raise the head of the bed when sitting him up as it would be easier on both of them. LPN-F raised the head of R2's bed then moved him into a seated position, still wearing the same gloves. R2 continued to tell LPN-F that she needed to do a better job cleansing around the catheter. LPN-F stated she would do this once he was standing in the lift. LPN-F and ULP-G then applied the sit to stand sling around R2 and stood him up using the lift. R2 again prompted LPN-F to do a better job of cleaning around the insertion site of the catheter. LPN-F then	0 510		

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0 510	Continued From page 4	0 510		

Continued From page 4

obtained another wipe and cleansed R2's penis and scrotum but did not cleanse gently around the urinary meatus. LPN-F and ULP-G then pulled up R2's pants and transferred him into his electric wheelchair. LPN-F did not remove her gloves or perform hand hygiene until after R2 was settled into his wheelchair.

On March 29, 2023, at 12:11 p.m. clinical nurse supervisor (CNS)-B stated she would expect when the LPNs assist the ULP with direct care services to refer to the tablet (device used to look up and document services for residents) to ensure all services were being performed. CNS-B further stated she would expect after performing catheter/pericare gloves would be removed and hands cleansed.

The licensee's competency form titled, "Skill: Catheter Care" dated February 2021, indicated: "Wash hands before and after any manipulation of the catheter site and/or apparatus. Always apply gloves for potential exposure to body fluids."

The licensee's Infection Prevention and Control Program document revised April 2020, indicated: "The Infection Control Program /QAPI (Quality Assurance and Performance Improvement) is responsible for reviewing infection surveillance practices and establishing policies and procedures for identifying, controlling, and monitoring infections and staff performance."

No further information provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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0 550	Continued From page 5	0 550		
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 email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the 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. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to 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. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 550		

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0 550	Continued From page 6 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 27, 2023, at 11:43 a.m. the surveyor toured the facility with director of marketing (DOM)-C. There were postings by the front entrance; however, there was no evidence of the grievance procedure or 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. DOM-C stated being unsure if that information was posted elsewhere. On March 27, 2023, at 1:05 p.m. licensed assisted living director (LALD)-A stated residents were given information upon admission related to the grievance procedure and ombudsman information. LALD-A further confirmed the grievance procedure including the ombudsman information was not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all	0 620		

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NAME OF PROVIDER OR SUPPLIER: **THE LEGACY OF FARMINGTON**
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0 620	Continued From page 7	0 620		

cases of suspected maltreatment are reported.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R8).

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:

R8's diagnoses included cognitive impairment and hypertension.

R8's 90-day Nursing Assessment dated February 22, 2023, indicated the licensee would provide medication administration to the resident by community unlicensed staff.

R8's progress note dated January 14, 2023, at 9:53 p.m., indicated this was a late entry for January 14, 2023, at 8:00 a.m. Staff brought from R8's room two cards of medication that belonged to different resident, Eliquis (blood thinner prescribed to prevent strokes and potentially fatal blood clots) 25 milligrams (mg), and metformin (used to prevent high blood sugar levels caused by diabetes) 1000 mg. The resident had been given these meds for the past three days by

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0 620	Continued From page 8	0 620		

accident before it was noticed, assessment was done, VS (vital signs): 131/70 (blood pressure), 97.4 (temperature), 65 (pulse), 20 (respirations), Sat 96% RA (oxygen saturation at room air), BG (blood glucose) 113. Notification done to family, DON (director of nursing) and NP (nurse practitioner). New order was given to monitor BG at lunch time, which was 123, and also monitor for tarry stools, bruises and hematuria (blood in the urine) which resident denied. R8 was fine on evening shift, no adverse reaction noted, will update on coming shift.

R8's MAARC report related to the above entry was submitted on January 16, 2023, at 15:49 (3:49 p.m.); the report was submitted 55 hours and 49 minutes after knowledge of the medication errors.

On March 28, 2023, at 1:37 p.m. clinical nurse supervisor (CNS)-B confirmed R8's medication errors were not reported within the required 24 hours. CNS-B stated she had reached out to the NP about the error, and it was determined there had been no adverse effects to the resident. CNS-B further stated they talked about the error as a group, and it was determined that it should be reported, even though it was late.

The licensee's Vulnerable Adult/Maltreatment - Communication, Prevention, and Reporting policy revised October 2022, indicated: All staff of Facility shall immediately make a report to the Minnesota Adult Abuse Reporting Center (MAARC).

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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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 required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-H). 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	0 650		

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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
0 650	Continued From page 10 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-H began providing direct care services for the licensee on August 1, 2021. ULP-H's record lacked an annual performance review. On March 30, 2023, at 3:15 p.m. licensed assisted living director (LALD)-A confirmed ULP-H's employee file did not include a current performance review. The licensee's Employee File Checklist dated April 2022, included employee performance reviews. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 11	0 810		

evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.
(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.
(d) Fire safety and evacuation plans shall be readily available at all times within the facility.
(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.
(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.

This MN Requirement is not met as evidenced by:
Based on observation, record review, and interview, the licensee failed to provide the complete minimum frequency of employee evacuation drills and the minimum required employee training on fire safety and evacuation. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

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0 810	Continued From page 12	0 810		

Continued From page 12

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 30, 2023, at approximately 1:40 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the regional environmental services lead (RESL)-K. At approximately 2:15 p.m., document review and interview with the RESL-K and the director of maintenance (DM)-J indicated the following:

1. The licensee lacked the required minimum employee training specifically on the fire safety and evacuation plan twice a year after new hire orientation for fire safety and evacuation. Tabletop drill records provided for review consisting of the first, second, and third shifts on the same date, 3/9/2023, noting all staff meetings, but lacked records of documented dates for employee training were provided for review to substantiate training for the year 2022.
2. The licensee lacked records to show that required employee fire evacuation drills performed to date. Fire drill evaluation forms (records) noting"tabletop only education all staff meeting" for the first, second, and third shifts on the same date, 3/9/2023, were provided for review. Beyond the tabletop drill forms provided, no other evacuation drill records were available or provided for review. Survey staff explained to the RESL-K and the DM-J that tabletop fire drills do not meet the requirements of the statutory required fire evacuation drills and in addition, the minimum required frequency is twice per year per shift with at least one evacuation every other month, totally six evacuation drills per year. All

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 13 drills must include evacuation. On March 30, 2023, at approximately 2:30 p.m., during the exit interview, the RESL-K and the DM-J acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study had been completed prior to providing services for one of four employees (unlicensed personnel (ULP)-H). This resulted in an immediate correction order on March 29, 2023, at 4:17 p.m.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 14	01290		

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

ULP-H began providing direct care services for the licensee under the assisted living facility with dementia care license (ALFDC) on August 1, 2021.

ULP-H's employee file included a background study dated June 5, 2019, under the licensee's previous comprehensive license. Upon review of the NETStudy 2.0 website, ULP-H was not included in the licensee's roster. The licensee lacked evidence a background study had been completed prior to ULP-H providing direct care services under the ALFDC license.

On March 29, 2023, at 4:17 p.m. licensed assisted living director (LALD)-A confirmed he checked the NETStudy 2.0 background study website and was unable to access ULP-H's information. At 5:10 p.m., LALD-A confirmed ULP-H worked unsupervised.

The licensee's HR 110: Pre-Employment Reference Checks policy effective/revised November 2019, indicated the ED (executive director) or designee will ensure that all applicants considered for a position are interviewed and appropriate background checks are completed prior to start of employment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	**22300 DENMARK AVENUE FARMINGTON, MN 55024**

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01290	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 30, 2023, the immediacy of correction order 1290 was removed; however, non-compliance remains at a scope and level of (I). TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ___ B. WING ___	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

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01620	Continued From page 16	01620		

resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for three of five residents (R3, R4, R5).

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

The findings include:

R3
R3's diagnoses included chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs), acute kidney failure, heart failure, and type II diabetes.

R3's Service Plan effective January 10, 2023, indicated R3 received services including medication administration.

R3's last two assessments were requested. Assessments dated May 11, 2022, September 7, 2022, and December 2, 2022, were provided. 107 days had passed between the May and September assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

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THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 17	01620		

On March 30, 2023, at 12:11 p.m. clinical nurse supervisor (CNS)-B confirmed R3's September 7, 2022, assessment had not been completed within 90 days as required.

R4
R4's diagnoses included hip fracture, and general malaise (weakness).

R4's Service Plan effective February 28, 2023, indicated R4 received services for assistance with activities of daily living (ADLs) and medication administration.

R4's last two assessments were requested. Assessments dated June 23, 2022, labeled the 14-day assessment, and October 4, 2022, labeled a 90-day assessment, were provided. 103 days had passed between the June and October assessments.

R5
R5's diagnoses included congestive heart failure and type II diabetes.

R5's Service Plan effective September 9, 2022, indicated R5 received services for assistance with ADLs and medication administration.

R5's last two assessments were requested. Assessments dated December 15, 2022, and March 29, 2023 (today), were provided. 104 days had passed between the December and March assessments.

On March 28, 2023, at 1:30 p.m. CNS-B confirmed the process for assessments was not to exceed 90 days and that R4 and R5's assessments were past 90 days. CNS-B stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

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01620	Continued From page 18 they had issues in delay of assessments, and now have a report driven by due date so every week the nurses review who is due that week. The licensee's Service Plan policy revised December 2022, indicated a registered nurse or licensed practical nurse under the direction of a registered nurse will review and monitor all health related services provided to the resident within 14 days of admission and at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
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 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 document the reason why medication administration was not	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

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01760	Continued From page 19	01760		

Continued From page 19

completed as prescribed for one of one resident (R3).

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

The findings include:

R3's diagnoses included chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs), acute kidney failure, heart failure, and type II diabetes.

R3's Service Plan effective January 10, 2023, indicated R3 received services including medication administration.

R3's physician orders signed March 2, 2023, included the following medications to be administered in the AM (morning):
- simvastatin (for high cholesterol) 20 milligrams (mg) one tablet by mouth every day at 8 AM; - allopurinol (for gout-a type of arthritis that causes inflammation of joints due to excess uric acid)300 mg one tablet by mouth every day at 9 AM;
- aspirin chewable 81 mg chew and swallow one tablet by mouth every day at 9 AM;
- Breo Ellipta inhaler 100-25 - inhale one puff by mouth every day at 9 AM for COPD;
- buspirone (for anxiety) 5 mg twice a day -take one tablet by mouth twice daily at 9 AM and 8 PM;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

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01760	Continued From page 20 - comolyn sodium spray (for allergies) 5.2/ACT (actuation) twice a day - instill one spray in each nostril three times daily at 9 AM, 8 PM; - Eliquis (a blood thinner) 5 mg take one tablet twice a day at 9 AM and 8 PM; - escitalopram (antidepressant) 10 mg take one tablet every day at 9 AM; - ferrous sulfate 325 mg take one tablet by mouth every day with breakfast - 9 AM; - fluticasone spray (for allergies) 50 micrograms (mcg) instill two sprays in each nostril twice daily at 9 AM and 8 PM; - gabapentin (for neuropathy-damage to the nerves) 400 mg take one capsule by mouth twice daily at 9 AM and 8 AM; - levothyroxine (for low thyroid) 50 mcg take one tablet by mouth every day at 9 AM; - lisinopril (for high blood pressure) 10 mg take one tablet by mouth every day at 9 AM; - Spiriva inhaler (for COPD) 2.5 mcg inhale two puffs by mouth every day at the same time each day at 9 AM; - triamcinolone lotion (for dermatitis- skin conditions characterized by red, itchy rashes) 0.1% apply topically to affected areas twice daily at 9 AM and 8 PM. On March 30, 2023, at 9:38 a.m. the surveyor asked R3 if she had received her morning medications yet. R3 confirmed staff had not yet administered her morning medications and further stated she usually received them around 11:00 a.m. when unlicensed personnel (ULP)-L was passing the pills. On March 30, 2023, at 11:36 a.m. ULP-L confirmed she had given R3 her medications prior to lunch. ULP-L showed the documentation of the medication administration that were signed off at 11:10 a.m. and 11:11 a.m. to the surveyor	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

(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 21	01760		

for verification. ULP-L stated she gave all R3's prescribed AM meds except the simvastatin as that medication was "out". The surveyor asked what they do when a resident runs out of a medication and ULP-L stated they would contact the nurse, but the simvastatin had been out for about a month now. ULP-L added that when the R3 first moved in, they had an issue getting this medication as well.

On March 30, 2023, at 12:11 p.m. clinical nurse supervisor (CNS)-B stated the staff passing medications has up to an hour before and an hour after the prescribed time to administer the medication. If a medication is going to be administered late, the med passer needs to contact a nurse. CNS-B confirmed ULP-L had not contacted her about administering R3's medications late but may have talked to another nurse. CNS-B confirmed ULP-L had attended the standup meeting that morning at 10:30 a.m. and would have expected all of her morning medications to have been administered prior to attending the meeting. CNS-B was also asked about R3's simvastatin medication being unavailable for an extended amount of time. CNS-B stated she would investigate it.

R3's medication administration record (MAR) dated March 2023, indicated the resident had not received simvastatin 20 mg from March 8, 2023, through March 30, 2023, except on March 11, 15, 25, 26, and 29, as those dates were signed out as administered.

On March 30, 2023, at 2:10 p.m. CNS-B stated she checked on R3's simvastatin order and it had been filled and delivered on March 8, 2023. CNS-B further stated she looked through R3's medication cabinet and found the blister card for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ____ B. WING ____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

(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 22 the simvastatin on the top shelf in the cabinet. CNS-B stated there was one pill punched out of the blister pack, but that was it. CNS-B also stated staff had been signing out the medication some of the time when it wasn't available. At 2:15 p.m., CNS-B provided the surveyor with times of administration for R3's AM medications during March 2023, and confirmed it had been a pattern for R3 to receive her AM medications late. The licensee's Medications & Treatments policy revised March 2021, indicated the ULP will follow the six rights of medication administration (right person, right medication, right time, right route, right dose, right chart/record to document that the medication was taken); to indicate no supply of required medication circle on the MAR (medication administration record) and indicate No Supply. The nurse is to call the pharmacy, family and medical practitioner, and document in tenant record. The licensee's Medications & Treatments policy revised March 2021, indicated under Documentation Electronic Medication Administration Record: 2. d. No Supply - To indicate no supply of required medication circle on the MAR and indicate No Supply. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

(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
01880	Continued From page 23	01880		

according to the manufacturer's directions and permit only authorized personnel to have access.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of five residents (R3).

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

The findings include:

R3's diagnoses included chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs), acute kidney failure, heart failure, and type II diabetes.

R3's Physician Orders dated March 2, 2023, included an order for oxycodone/APAP (acetaminophen) tab (a highly addictive class II narcotic) 7.5/325 milligrams - take one tablet by mouth every 6 hours as needed for chronic pain (maximum three per day) (maximum APAP 4GM (grams)/24 HRS). May self-administer. The Physician Orders also indicated: Okay for facility to manage and administer medications due to intermittent confusion.

On March 30, 2023, at 9:38 a.m. R3 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

(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
01880	Continued From page 24	01880		

Continued From page 24

observed seated in a chair in her living room. A prescription bottle of pills was observed on the side table next to her. R3 stated the facility managed and administered all of her medications except her pain pills which she took on her own. R3 stated the pills were oxycodone and she could take them three times a day, but she only took them twice a day. R3 further stated she saw the pain doctor once a month and he counted the pills "to make sure I don't take too many". The surveyor asked R3 if she could look at the bottle of pain pills and confirmed they were the prescribed oxycodone/APAP 7.5/325 mg tablets. R3 stated she also took melatonin (a medication to help with sleep) gummies on her own that she purchased a couple months ago. She used to take the melatonin pills supplied by the pharmacy, but it was cheaper to buy the melatonin gummies on her own. R3 confirmed staff knew she had the gummies and was taking them independently.

On March 30, 2023, at 11:36 a.m. unlicensed personnel (ULP)-L confirmed R3 administered her own oxycodone, and staff didn't do anything with it including counting it. ULP-L further confirmed R3 didn't lock up the oxycodone. ULP-L stated one time she observed the oxycodone on R3's table and brought it down to the nurse. The nurse informed ULP-L that R3 self-administered the oxycodone and directed R3 to return the bottle to the resident's apartment.

On March 30, 2023, at 12:11 p.m. clinical nurse supervisor (CNS)-B stated being unaware R3 had a controlled substance unlocked in her apartment that she could self-administer and stated it was a high risk medication for diversion and should be counted and secured.

The licensee's Controlled Substances policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

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01880	Continued From page 25	01880		

revised December 2022, indicated all controlled substances must be accounted for in accordance with the MN Board of Pharmacy Rules and State Regulations. Scheduled substance will be stored in a double locked system (locked in narc box in apartment). Separate from other medications.

No further information provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

01940 SS=D — 144G.72 Subd. 3 Individualized treatment or therapy managemen — 01940

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

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01940	Continued From page 26 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include on the service plan a written statement of the treatment or therapy services provided for two of three residents (R3, R5) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 27, 2023, at 10:44 a.m. clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-A confirmed the licensee provided treatment and therapy services to residents as prescribed. R3 R3's diagnoses included chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs).	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ____ B. WING ____	03/30/2023

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01940	Continued From page 27	01940		

Continued From page 27

R3's Physician Orders dated March 2, 2023, included: Okay to self-manage oxygen 2 liter continuous.

R3's Service Checkoff List dated March 2023, included oxygen management services five times daily and as needed. The Service Checkoff List directed staff to assist R3 with switching from her portable tank to her concentrator or from the concentrator to the portable tank; to ensure the tubing is securely attached and the resident is receiving the oxygen through her nasal cannula; assist with oxygen; check oxygen rate, and assist to place oxygen cannula.

On March 30, 2023, at 9:38 a.m. R3 was observed in her room utilizing oxygen via nasal cannula from an oxygen concentrator. R3 confirmed staff check and assist her with her oxygen.

R3's Service Addendum to the Assisted Living Contract effective January 10, 2023, identified R3 received medication administration services, and monthly vital signs. The service agreement failed to identify the treatment of oxygen management.

On March 20, 2023, at 1:06 p.m. clinical nurse supervisor (CNS)-B confirmed R3's Service Plan had not been updated to include oxygen management services.

R5
R5's diagnoses included congestive heart failure and type II diabetes.

R5's Physician Orders dated March 28, 2023, included an order to provide a fluid restriction of 2000 cc (cubic centimeters) per day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ____ B. WING ____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

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01940	Continued From page 28 R5's record did not contain evidence of management for a daily fluid restriction. R5's Service Checkoff List dated March 2023, did not include a 2000 cc fluid restriction. On March 29, 2023, at 11:20 a.m. CNS-B confirmed the physician's order for a 2000 cc fluid restriction per day was not on the service plan or the treatment plan. The licensee's Service Plan policy revised December 2022, indicated any changes to the service plan or agreement must be in writing and must be signed by the client or the client's responsible person and the RN (registered nurse). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	**22300 DENMARK AVENUE FARMINGTON, MN 55024**

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01960	Continued From page 29	01960		

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to document treatment administration for one of four residents (R5) who received treatments.

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

The findings include:

R5's diagnoses included congestive heart failure and type II diabetes.

R5's March 2023, treatment plan included daily weights before breakfast. Staff signed off daily that it was completed, but there was no evidence of the recorded weight.

On March 29, 2023, at 11:20 a.m. clinical nurse supervisor (CNS)-B confirmed the electronic medical record was not set up correctly to trigger ULP staff to add the resident's weight.

The licensee's Medications and Treatment policy last updated March 2021, indicated all treatment/therapy services are to be administered as prescribed and documented.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ____ B. WING ____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01960	Continued From page 30 days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of four residents (R5) who received treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on March 27, 2023, at 10:44 a.m. clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-A confirmed the licensee provided treatment and therapy services to residents as prescribed.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33271	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED 03/30/2023

NAME OF PROVIDER OR SUPPLIER: **THE LEGACY OF FARMINGTON**

STREET ADDRESS, CITY, STATE, ZIP CODE: **22300 DENMARK AVENUE FARMINGTON, MN 55024**

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01970	Continued From page 31 R5's diagnoses included congestive heart failure and type II diabetes. R5's service plan dated February 25, 2023, did not include farrow wraps. On March 28, 2023, at 7:30 a.m. the surveyor observed unlicensed personal (ULP)-E apply farrow wraps to R5's lower legs. R5's provider orders dated March 29, 2023, (after the survey started) included an order for applying farrow wraps/Velcro compression garments applied daily in AM and removed daily in PM. On March 29, 2023, at 11:20 a.m. CNS-B confirmed R5's file did not contain an order for farrow wraps and should have one. The licensee's Medications and Treatment policy updated March 2021, indicated the licensed nurse will ensure that the prescriber review/renews a medication or treatment order at least every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

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THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

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02040	Continued From page 32	02040		

following additional requirements:
(1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and
(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.

This MN Requirement is not met as evidenced by:
Based on the document review and interview, the licensee lacked a complete site-specific hazard vulnerability or safety risk assessment plan to identify safety risks/hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services.

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

The findings include:

On March 30, 2023, at approximately 1:40 p.m., a survey staff received the Hazard and Vulnerability Assessment Plan (undated). Document review indicated the license lacked a memory care site-specific mitigation plan as part of the safety risk assessment on and around the property to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ____ B. WING ____	03/30/2023

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02040	Continued From page 33 protect the memory care residents from harm. The finding was confirmed during the document interview with the regional environmental services lead (RESL)-K and the director of maintenance (DM)-J at approximately 2:30 p.m. Survey staff discussed the findings and explained that all potential memory care safety risks or vulnerabilities on and around the property must be assessed and mitigated to specifically protect the memory care residents from harm. On March 30, 2023, at approximately 3:00 p.m., during the exit interview, the RESL-K and the DM-J acknowledged the above findings. The RESL-K agreed to reach out to the corporate office to update the plan to be memory care resident site-specific risks/hazard vulnerabilities and mitigations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

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02310	Continued From page 34	02310		

two of five residents (R5, R6) with side rails. This resulted in an immediate correction order on March 27, 2023, at approximately 2:45 p.m.

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

The findings include:

R5
R5's diagnoses included congestive heart failure.

R5's Service Plan dated March 12, 2023, included daily medication administration and activities of daily living (ADL).

On March 27, 2023, at 1:30 p.m. the surveyor along with unlicensed personnel (ULP)-D observed a hospital bed in R5's room with bilateral side rails at the head of the bed in the up position. The side rails were firmly secured to the bed.

R5's side rail assessment dated March 27, 2023, (today), indicated the family had been notified today about the risks and benefits of side rail use, and gave their verbal acknowledgement.

On March 27, 2023, at 2:45 p.m. clinical nurse supervisor (CNS)-B verified R5 did not have a side rail assessment with measurements, and had not discussed the risks and benefits of side rail use with R5's family until today. CNS-B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ____ B. WING ____	03/30/2023

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THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

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02310	Continued From page 35	02310		

stated she was not aware when the hospital bed arrived or how long the side rails have been on.

R6
R6's diagnoses included Chronic obstructive pulmonary disease.

R6's Service Plan dated February 25, 2023, included daily medication administration and assistance with ADLs.

On March 27, 2023, at 1:45 p.m. the surveyor along with ULP-D observed bilateral halo assistive devices near the head of the bed. The assistive devices were firmly secured to the bed.

R6's side rail assessment dated March 27, 2023, (today) was completed after R6's family was educated on the risks and benefits of halo use.

On March 27, 2023, at 4:00 p.m. CNS-B indicated the licensee monitors for any recalls of the halo device and places a copy of the manufacturer guidelines in the resident's record; however, R6's record did not include any of the information.

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 identified; "Patients who have problems with

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	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

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02310	Continued From page 36 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." The licensee's Resident Assistive Device policy revised December 2022, indicated facility clinical staff will be responsible for completing the appropriate assessments and reviewing the risk benefits of such devices with residents and responsible parties. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 29, 2023, the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of (G). TIME PERIOD FOR CORRECTION: Two (2) days	02310		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ____ B. WING ____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

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03000	Continued From page 37 required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	**22300 DENMARK AVENUE FARMINGTON, MN 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 38 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R8). 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: R8's diagnoses included cognitive impairment and hypertension. R8's 90-day Nursing Assessment dated February 22, 2023, indicated the licensee would provide medication administration to the resident by community unlicensed staff. R8's progress note dated January 14, 2023, at 9:53 p.m., indicated this was a late entry for January 14, 2023, at 8:00 a.m. Staff brought from R8's room two cards of medication that belonged to different resident, Eliquis (blood thinner prescribed to prevent strokes and potentially fatal blood clots) 25 milligrams (mg), and metformin (used to prevent high blood sugar levels caused by diabetes) 1000 mg. The resident had been given these meds for the past three days by accident before it was noticed, assessment was	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33271	A. BUILDING: ______ B. WING ______	03/30/2023

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03000	Continued From page 39 done, VS (vital signs): 131/70 (blood pressure), 97.4 (temperature), 65 (pulse), 20 (respirations), Sat 96% RA (oxygen saturation at room air), BG (blood glucose) 113. Notification done to family, DON (director of nursing) and NP (nurse practitioner). New order was given to monitor BG at lunch time, which was 123, and also monitor for tarry stools, bruises and hematuria (blood in the urine) which resident denied. R8 was fine on evening shift, no adverse reaction noted, will update on coming shift. R8's MAARC report related to the above entry was submitted on January 16, 2023, at 15:49 (3:49 p.m.); the report was submitted 55 hours and 49 minutes after knowledge of the medication errors. On March 28, 2023, at 1:37 p.m. clinical nurse supervisor (CNS)-B confirmed R8's medication errors were not reported within the required 24 hours. CNS-B stated she had reached out to the NP about the error, and it was determined there had been no adverse effects to the resident. CNS-B further stated they talked about the error as a group, and it was determined that it should be reported, even though it was late. The licensee's Vulnerable Adult/Maltreatment - Communication, Prevention, and Reporting policy revised October 2022, indicated: All staff of Facility shall immediately make a report to the Minnesota Adult Abuse Reporting Center (MAARC). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		