DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 23, 2025

Licensee
Loving Care Cottage LLC
7740 Hadley Avenue South
Cottage Grove, MN 55016

RE: Project Number(s) SL37940016

Dear Licensee:

On May 6, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 19, 2024 and the follow-up survey completed on March 11, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 19, 2024 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 19, 2024, found not corrected at the time of the May 6, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0115 - Licensure Categories - 144g.10 Subd. 2 - $500.00
0340 - Correction Orders - 144g.30 Subd. 5 - $500.00
0630 - Compliance With Requirements For Reporting Ma - 144g.42 Subd. 6 (b)
0650 - Staff Records - 144g.42 Subd. 8 (a)
0660 - Tuberculosis Prevention And Control - 144g.42 Subd. 9 - $500.00
0680 - Disaster Planning And Emergency Preparedness - 144g.42 Subd. 10 - $500.00
0730 - Contents Of Resident Record - 144g.43 Subd. 3 - $500.00
1650 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (f) - $500.00
1730 - Individualized Medication Management Plan - 144g.71 Subd. 5

The details of the violations noted at the time of this follow-up survey completed on May 6, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37940	A. BUILDING: _____ B. WING _____	R 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE COTTAGE LLC	7740 HADLEY AVENUE SOUTH COTTAGE GROVE, MN 55016

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#37940016-2 On May 5, 2025, to May 6, 2025, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 19, 2024. At the time of the survey, there were 6 residents; 6 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 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 SUBDIVISION 1-3.	
{0 115} SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are	{0 115}		

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{0 115}	Continued From page 1 established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain an assisted living facility with dementia care license when the licensee provided dementia care services, and utilized a lock to secure the facility so residents could not exit the locked door without entering a code. This had the potential to affect all five residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility received an assisted living facility license effective August 1, 2021, with an initial capacity of five beds.	{0 115}		

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{0 115}	Continued From page 2 The licensee's renewal application, dated August 7, 2024, indicated the assisted living license category applied for was assisted living, with no request for dementia care, and indicated an increased total licensed resident capacity of six. On May 5, 2025, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on December 19, 2024. On May 5, 2025, at 9:15 a.m., the surveyor observed a coded lock on the inside of the front door on the main floor of the facility where all the residents resided. On May 5, 2025, at 10:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated licensee had not updated the licensee's assisted living license to an assisted living with dementia care license since the last survey and planned on applying for a dementia care license during the licensee's next license renewal. No further information was provided.	{0 115}		
{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, an agent of the facility, or staff 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 email copies	{0 340}		

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{0 340}	Continued From page 3 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: (1) 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; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed December 19, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 19, 2024, the licensee was provided an exit email related to the conclusion of	{0 340}		

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{0 340}	Continued From page 4 the licensee's initial survey. The email was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and included a link hosted on the Minnesota Department of Health's website for the Correction Order Documentation Guidelines document. On February 10, 2025, the licensee received the results of the survey concluded on December 19, 2024. The longest time period for correction (the time frame the licensee must document and correct orders) was 21 days from the date the licensee received their results. This date was March 3, 2025. On May 5, 2025, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 19, 2024. The licensee's plans of correction (POC) from survey dated December 19, 2024, lacked a documented plan of correction for the following orders: -0115, 114G.10 Subd. 2. Licensure categories; -0630, 114G.42 Subd. 6. Abuse prevention plan; -0650, 114G.42 Subd. 8. Employee records; -0660, 114G.42 Subd. 9. Tuberculosis prevention and control; -0680, 114G.42 Subd. 10. Disaster planning and emergency preparedness plan; -0730, 114G.43 Subd. 3. Contents of resident record; -1530, 1146.64 Subd. (a) (1-2) Training in dementia care required; -1650, 144G.70 Subd. 4. (f) Service plan, implementation, and revisions to service plan; -1730, 144G.71 Subd. 5. Individualized medication management plan;	{0 340}		

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{0 340}	Continued From page 5 On May 5, 2025, at 10:30 a.m., LALD/CNS-A stated licensee had not corrected all the orders from December 19, 2024, survey and was a work in progress. No further information provided.	{0 340}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before	{0 480}		

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{0 480}	Continued From page 6 storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 630} SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person	{0 630}		

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{0 630}	Continued From page 7 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 5, 2025, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on December 19, 2024. R2 R2 was admitted on February 5, 2023. R2's medical record lacked: -individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; and -the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.	{0 630}		

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{0 630}	Continued From page 8 R5 R5 was admitted on June 1, 2021. R5's medical record included a Vulnerability/Abuse Prevention Plan, dated June 1, 2022. The form lacked R5's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On May 5, 2025, at 12:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 and R5's IAPPs were not updated with the required content since the last survey and were a work in progress. The licensee's 6.05 Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated "[Licensee] will develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults." Additionally, indicated "1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults." No further information was provided.	{0 630}		
{0 650} SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	{0 650}		

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{0 650}	Continued From page 9 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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 maintain current records of each paid staff member, each regularly scheduled volunteer providing services, for two of two employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, volunteer (V)-F). 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 pattern scope (when more than a limited number of residents are affected, more than a limited	{0 650}		

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{0 650}	Continued From page 10 number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 5, 2025, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on December 19, 2024. LALD/CNS-A LALD/CNS-A was hired on May 1, 2021, and provided supervisory nursing services and direct nursing care for the licensee's residents. LALD/CNS-A lacked an employee record with the following required content: -records of orientation, required annual training and infection control training, and competency evaluations; -current job description; -documentation of annual performance reviews that identify areas of improvement needed and training needs; and -verification that required health screenings under subdivision 9 have taken place and the dates of those screenings. V-F V-F provided weekly spiritual care services and administrative services for licensee since May 1, 2021. V-F lacked an employee record with the following required content: -records of orientation, required annual training and infection control training, and competency evaluations; -current job description, including qualifications, responsibilities, and identification of staff persons	{0 650}		

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{0 650}	Continued From page 11 providing supervision; and -verification that required health screenings under subdivision 9 have taken place and the dates of those screenings. On May 5, 2025, at 12:40 p.m., LALD/CNS-A stated licensee had not completed the required content for LALD/CNS-A and V-F's employee files were a work in progress. The licensee's 4.05 Employee Records policy, dated August 1, 2021, indicated, "1. Employee records for each person will include: -Evidence of current professional licensure, registration, or certificate, if required -Records of all training and in-service education required and/or provided including record of competency testing as required -Current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any -Documentation of annual performance reviews that identify areas of improvement needed and training needs -For individuals providing Assisted Living services, verification that required health screenings for Tuberculosis {TB) have taken place and the dates of those screenings. (recommended to keep medical information in a separate employee medical file) -Documentation of a competed criminal background study -Evidence that a reference check has been completed -Verification of completed orientation and annual training and competency testing as required. In addition, included "Employee records will be retained for at least three (3) years after an employee, volunteer, or contractor ceases to be employed by, provide services at, or be under	{0 650}		

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{0 650}	Continued From page 12 contract with [Licensee]." No further information was provided.	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a TB history and symptom screening, TB baseline testing and TB transmission training for one (volunteer (V)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	{0 660}		

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{0 660}	Continued From page 13 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 May 5, 2025, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on December 19, 2024. V-F volunteered at the facility weekly and provided spiritual care services for the residents since May 1, 2021. V-F lacked a record with documentation of baseline testing, TB history and symptom screen, and TB transmission training. On May 5, 2025, at 12:55 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated V-F had not yet completed a TB test, TB history and symptom screening, and TB transmission training but planned to get these required items completed. The Minnesota Department of Health (MDH) Assisted Living Resources and Frequently Asked Questions website updated December 13, 2024 included under Tuberculosis Screening "Each facility must establish and maintain a comprehensive tuberculosis (TB) 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	{0 660}		

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{0 660}	Continued From page 14 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers." Also, indicated "Each provider licensed by MDH is required to complete a TB risk assessment annually. Completion of this assessment will assist providers in the development of an infection control committee and in determining the frequency of screening." Additionally, noted "Baseline TB screening is required at the time of hire for all health care personnel in Minnesota." The licensee's 8.16 Tuberculosis Screening policy, dated August 1, 2021, indicated "Procedure: 2. The facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health." Also, included "Staff Screening, Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented.	{0 660}		

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{0 660}	Continued From page 15 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis." 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 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	{0 680}		

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{0 680}	Continued From page 16 licensee failed to have a written emergency preparedness plan (EPP) with all the required content. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 5, 2025, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on December 19, 2024. The licensee's EPP dated February 16, 2022, lacked an individualized plan to include all the required content below: -quarterly review of missing resident policy; -annual review of the emergency preparedness plan policy; -emergency prep training program which includes maintain documentation of all EP training and EP training annually; and -emergency preparedness testing requirements. On May 5, 2025, at 1:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee had not completed the EPP with all the required content since the last survey and was a work in progress. The licensee's 2.28 Missing Resident policy dated August 1, 2021, indicated, "[Licensee] will review	{0 680}		

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{0 680}	Continued From page 17 this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented." The licensee's 9.02 Disaster Planning and Emergency Preparedness policy dated August 1, 2021, included, "On an annual basis, [Licensee] will make available training regarding emergency and disaster response to all residents of the facility." No further information was provided.	{0 680}		
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services;	{0 730}		

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{0 730}	Continued From page 18 (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation that services were provided as identified in the service plan for two of two residents (R2, 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) 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).	{0 730}		

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{0 730}	Continued From page 19 The findings include: On May 5, 2025, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on December 19, 2024. R2 R2 was admitted on February 5, 2023. R2's Residential Services Plan dated December 1, 2023, indicated R2 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R2's service delivery records lacked documentation of who provided the services and at what time the service was provided. R5 R5 was admitted on June 1, 2022. R5's Services Plan dated June 1, 2022, indicated R5 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R5's service delivery records lacked documentation of who provided the services and at what time the service was provided. On May 5, 2025, at 1:50 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the licensee had not updated the process yet for the documentation of resident services provided to daily versus the current weekly process and planned to update the process soon. The licensee's 2.37 Resident Record -	{0 730}		

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{0 730}	Continued From page 20 Documentation policy dated August 1, 2021, indicated, "Staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to resident. All documentation must include the signature and title of the person who performed the service or administered the medication, treatment, or therapy. Initials may be used if there is a completed signature page included in the documentation." No further information was provided.	{0 730}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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;	{0 780}		

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{0 780}	Continued From page 21 This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this survey.	
{0 790} SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.	
{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) staff 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	{0 810}		

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{0 810}	Continued From page 22 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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 staff 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:	{0 810}	Not reviewed during this survey.	
{01530} SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed	{01530}		

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{01530}	Continued From page 23 at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for two of two employees, (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 5, 2025, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey	{01530}		

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{01530}	Continued From page 24 completed on December 19, 2024. ULP-C and ULP-D were hired July 1, 2024, and March 12, 2024, respectively, to provide direct care services. ULP-C and ULP-D's employee records included three hours of dementia care training, five hours less than the required eight hours of dementia care training completed within 160 hours of the employment start date. On May 5, 2025, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she did not have any additional dementia care training documented for ULP-C or ULP-D and planned on having the full eight hours of training documented. The licensee's 3.01 ALDC Additional Dementia Staff Training policy dated June 2021, indicated, "2. Training will be documented and will indicate staff knowledge and understanding of such training." The policy also included, "5. Staff Training. a. Staff will be trained to provide a person-centered care approach. b. All direct care staff assigned to provide care for residents with dementia will be trained to work with residents with Alzheimer's disease and other dementias. c. Staff training will include the following topics: i. Understanding cognitive impairment, and behavioral and psychological symptoms of dementia; and ii. Standards of dementia care, including nonpharmacological dementia care practices that are person-centered and evidence informed." No further information was provided.	{01530}		

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{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for three of three residents (R2, R3, R5). This practice resulted in a level two violation (a	{01650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37940	A. BUILDING: _____ B. WING _____	R 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE COTTAGE LLC	7740 HADLEY AVENUE SOUTH COTTAGE GROVE, MN 55016

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{01650}	Continued From page 26 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 May 5, 2025, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on December 19, 2024. R2 R2 was admitted on February 5, 2023. R2's record lacked a service plan with the following requirements: -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and	{01650}		

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{01650}	Continued From page 27 declarations made by the resident under those chapters. R3 R3 was admitted on April 8, 2023. R3's record lacked a service plan with the following requirements: -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R5 R5 was admitted on June 1, 2022. R5's Services Plan dated June 1, 2022, lacked the following information: -a contingency plan that includes: -the names and contact information of persons the resident wishes to have notified in an	{01650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01650}	Continued From page 28 emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On May 5, 2025, at 2:30 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the licensee had not updated the process yet for the documentation of the required content to be included with the service plan and planned to update the process soon. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated, "9. A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes: i. Actions Loving Care Cottage LLC will take if scheduled services cannot be provided ii. Information regarding how the resident can contact Loving Care Cottage LLC	{01650}		

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{01650}	Continued From page 29 iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency v. How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned." No further information was provided.	{01650}		
{01730} SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed	{01730}		

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{01730}	Continued From page 30 personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan with the required content for two of two residents (R2, 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 5, 2025, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey	{01730}		

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{01730}	Continued From page 31 completed on December 19, 2024. R2 R2 was admitted on February 5, 2023. R2's medical record lacked an individualized medication management plan with the following required content including: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. R5 R5 was admitted on June 1, 2022. R5's medical record included a Medication Assessment Form dated May 27, 2022, but lacked an individualized medication management plan with the following required content including: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On May 5, 2025, at 2:45 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the licensee had not yet completed an individualized medication	{01730}		

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{01730}	Continued From page 32 management plan with the required content for R2 or R5 and was a work in progress. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated "For each resident at [Licensee] medication management services, the facility will prepare and include in the service plan a written statement of the medication management services that will be provided to the resident." Also, included [Licensee] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided; b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; c. Documentation of specific resident instructions relating to the administration of medications; d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; e. Identification of medication management tasks that may be delegated to unlicensed personnel; f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions." No further information provided.	{01730}		

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Electronically Delivered

April 9, 2025

Licensee
Loving Care Cottage LLC
7740 Hadley Avenue South
Cottage Grove, MN 55016

RE: Project Number(s) SL37940016

Dear Licensee:

On March 11, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 19, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 19, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 19, 2024, found not corrected at the time of the March 11, 2025, follow-up survey and/or subject to penalty assessment are as follows:

2310 - Appropriate Care And Services - 144g.91 Subd. 4 (a) - $500.00

The details of the violations noted at the time of this follow-up survey completed on March 11, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

IMPOSITION OF FINES:

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

§144G.20.

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

We urge you to review these orders carefully. If you have questions, please contact Renee Anderson at 651-201-5871.

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

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#37940016-1 On March 11, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow up on orders issued pursuant to a survey completed on December 19, 2024. At the time of the survey, there were five residents; five receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued. An immediate correction order was previously issued for 2310, related to side rail assessments. Upon follow-up, the deficiency was partially corrected and the order is reissued at a decreased scope and severity of level 2, widespread.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 115} SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are	{0 115}		

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{0 115}	Continued From page 1 established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by:	{0 115}	Not reviewed during this follow up survey.	
{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, an agent of the facility, or staff 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 email 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:	{0 340}		

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{0 340}	Continued From page 2 (1) 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; and This MN Requirement is not met as evidenced by:	{0 340}	Not reviewed during this follow up survey.	
{0 430} SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by:	{0 430}	Not reviewed during this follow up survey.	

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{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request 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:	{0 460}	Not reviewed during this follow up survey.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius	{0 480}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 480}	Continued From page 4 and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be	{0 480}		

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{0 480}	Continued From page 5 provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this follow up survey.	
{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:	{0 510}	Not reviewed during this follow up survey.	
{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	{0 550}		

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{0 550}	Continued From page 6 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:	{0 550}	Not reviewed during this follow up survey.	
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}	Not reviewed during this follow up survey.	
{0 650} SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The	{0 650}		

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{0 650}	Continued From page 7 records must include the following infomation: (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:	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled	{0 660}	Not reviewed during this follow up survey.	

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{0 660}	Continued From page 8 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:	{0 660}	Not reviewed during this follow up survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	{0 680}		

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{0 680}	Continued From page 9 This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this follow up survey.	
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	{0 730}		

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{0 730}	Continued From page 10 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:	{0 730}	Not reviewed during this follow up survey.	
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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	{0 780}		

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{0 780}	Continued From page 11 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this follow up survey.	
{0 790} SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this follow up survey.	
{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) staff actions to be taken in the event of a fire	{0 810}		

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{0 810}	Continued From page 12 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) Staff 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 staff 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: Not reviewed during this follow up survey.	{0 810}		
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition	{01370}		

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

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{01380}	Continued From page 14	{01380}		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}	Not reviewed during this follow up survey.	
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered	{01440}		

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{01440}	Continued From page 15 nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	{01440}	Not reviewed during this follow up survey.	
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the	{01530}		

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{01530}	Continued From page 16 requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this follow up survey.	
{01620} SS=F	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 resident moves in, whichever is earlier.	{01620}		

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{01620}	Continued From page 17 This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this follow up survey.	
{01640} SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this follow up survey.	
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include:	{01650}		

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{01650}	Continued From page 18 (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	{01650}	Not reviewed during this follow up survey.	
{01710} SS=F	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	{01710}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37940	A. BUILDING: _____ B. WING _____	R 03/11/2025

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{01710}	Continued From page 19 that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by:	{01710}	Not reviewed during this follow up survey.	
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration,	{01730}		

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{01730}	Continued From page 20 verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	{01730}	Not reviewed during this follow up survey.	
{01770} SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by:	{01770}	Not reviewed during this follow up survey.	
{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:	{01880}		

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{01880}	Continued From page 21	{01880}	Not reviewed during this follow up survey.	
{02310} SS=F	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 provide care and services according to acceptable health care standards, medical or nursing standards for three of three residents (R2, R4, R5) who utilized hospital style bed rails. 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 March 11, 2025, at 10:30 a.m., the surveyor observed the main floor of the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. R2, R4, and R5 shared a bedroom. R2, R4, and R5's hospital style bed had bilateral upper side rails, all in the upright position.	{02310}		

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{02310}	Continued From page 22 R2 R2's Resident Plan of Care for March 2025, indicated R2 received services including assistance with bathing, laundry, housekeeping, dressing, grooming, toileting, ambulation, overnight monitoring, and medication management. R2's medical record included a Uniform Assessment Tool with a 90 Day Assessment dated, December 19, 2024, on page 19, section titled, "Notes," indicated, "Side rail zone 1,3 <4.75 in and need appropriate after assessment." Also, included "POA approved." R2's medical record lacked: -documentation of measurements of zones of entrapment. R4 R4's Resident Plan of Care for March 2025, indicated R4 received services including assistance with bathing, laundry, housekeeping, dressing, grooming, toileting, overnight monitoring, and medication management. R4's medical record included a Uniform Assessment Tool with a 90 Day Assessment dated, December 17, 2024, on page 19, section titled, "Notes," indicated, "Bed rail tightened for zoning requirements meets Zone 1,2,3,4 1 in requirements/needed for bed mobility comfort and positioning call button assessed and not appropriate due to cognition/video monitor appropriate at this time/ POA educated." R4's bed rail assessment lacked: -documentation of measurements of zones of entrapment.	{02310}		

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{02310}	Continued From page 23 R5 R5's Resident Plan of Care for March 2025, indicated R5 received services including assistance with bathing, laundry, housekeeping, dressing, grooming, toileting, ambulation, overnight monitoring, and medication management. R5's medical record included a Uniform Assessment Tool, with a 90 Day Assessment dated, December 17, 2024, on pages 18 and 19, section titled "Notes," indicated, "Assessed side rail use is still effective for resident use as needs supports and stability zoning 1,3 <4.75 complete and rail secure." In addition, section titled, "Updates/Changes to Service Plan," included, "Bed rail assessed Bed alarm assessed and in working order/ approved by family." R5's bed rail assessment lacked: -documentation of measurements of zones of entrapment. On March 11, 2025, at 10:44 a.m., LALD/CNS-A stated when she assessed R2, R4, and R5's side rail measurements she made sure the side rails were less than the measurements required. LALD/CNS-A stated she did not document exact measurements of the zones. On March 11, 2025, at 11:50 a.m., the surveyor educated LALD/CNS-A, as requested, on actual zone measurements for one of the resident's hospital style beds with bilateral upper side rails in the R2, R4, and R5's shared bedroom. LALD/CNS-A verbalized she would follow up and get the exact measurements of all four zones and document in each of the resident's medical records.	{02310}		

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{02310}	Continued From page 24 The FDA's 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 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 Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQ's), last updated December 12, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences;	{02310}		

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{02310}	Continued From page 25 - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee's 6.28 Side rails policy dated August 1, 2021, included "1. When side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. If the side rail is acting as a restraint, appropriate action should be taken." Also, indicated "1. Staff from [Licensee] will determine if the side rail is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below: a. The side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. c. The side rail design is consistent with the FDA's [Food and Drug Administration] 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4.75." No further information was provided.	{02310}		

Electronically Delivered

February 10, 2025

Licensee
Loving Care Cottage LLC
7740 Hadley Avenue South
Cottage Grove, MN 55016

RE: Project Number(s) SL37940016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 19, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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. 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.

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,



Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37940016 On December 16, 2024, through December 19, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility license. An immediate order was identified on December 16, 2024, for SL37940016-0 correction tag 2310. The licensee submitted an acceptable plan of correction; the scope and severity remained at level 3, widespread. An immediate order was identified on December 17, 2024, for SL37940016-0 correction tag 1290. The licensee submitted an acceptable plan of correction; the scope and severity remained at level 3, widespread.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 115 SS=F	144G.10 Subd. 2 Licensure categories	0 115		

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0 115	Continued From page 1 (a) The categories in this subdivision are established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain an assisted living facility with dementia care license when the licensee provided dementia care services, and utilized a lock to secure the facility so residents could not exit the locked door without entering a code. This had the potential to affect all five residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility received an assisted living facility license effective August 1, 2021, with an initial	0 115		

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0 115	Continued From page 2 capacity of five beds. On December 16, 2024, at 10:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee cared for residents with dementia. In addition, LALD/CNS-A verbalized the licensee used bed alarms on all the resident's beds for safety purposes and when the bed alarm went off the employees knew to check on the resident right away. LALD/CNS-A added, the licensee reviews a consent form with the residents' representatives before use. On December 16, 2024, at 11:07 a.m., the surveyor observed a coded lock on the inside of the front door on the first floor of the facility where all the residents resided. On December 16, 2024, at 11:20 a.m., LALD/CNS-A stated the front door coded lock was only used by the employees. LALD/CNS-A stated the residents all had a diagnosis of dementia, and were at risk for elopement. Also, LALD/CNS-A verbalized the residents could go out the back sliding glass door which was not locked, but the residents did not go out without a caregiver. The surveyor observed a back sliding glass door that opened to a deck and fenced in backyard. R2, R4, and R5's uniform assessment forms dated September 5, 2024, June 29, 2024, and September 1, 2023, respectively, included an elopement assessment. The assessments noted they were all at high risk for elopement. R5's Vulnerability/Abuse Prevention Plan dated June 1, 2022, in the section labeled wandering/elopement, indicated interventions to	0 115		

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0 115	Continued From page 3 be used by the employees with R5 included, "stand by assist, tab alarms, door code, and bed alarm." On December 16, 2024, at 1:00 p.m., unlicensed personnel (ULP)-B stated the code lock on the inside of the front door was only used by the employees. LALD/CNS-A verbalized the device on the top of the inside front door was a chime to notify the employees the door had been opened. The licensee's renewal application, dated August 7, 2024, indicated the assisted living license category applied for was assisted living, with no request for dementia care, and indicated an increased total licensed resident capacity of six. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 115		
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, an agent of the facility, or staff 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 email 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	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37940	A. BUILDING: _____ B. WING _____	12/19/2024

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0 340	Continued From page 4 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: (1) 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; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to record actions taken to comply with all correction orders from a survey completed March 17, 2022. The lack of action to ensure compliance with regulations 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The result of the licensee's previous survey, concluded on March 17, 2022, was sent to the licensee via email on April 21, 2022. The result communication indicated the licensee was granted an assisted living license. The longest time period for correction (the time frame in which the licensee must document and correct orders) was 21 days from the date the licensee received	0 340		

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0 340	Continued From page 5 their results, or May 12, 2022. The licensee's plans of correction (POC) from survey dated March 17, 2022, lacked a documented plan of correction for the following orders: -1370, 144G.61 Subd. 2. (a) Training and evaluation of unlicensed personnel; -1380, 144G.61 Subd. 2. (b) Training and evaluation of unlicensed personnel; -1470, 144G.63 Subd. 2. Content of required orientation; -1480, 144G.63 Subd. 3. Orientation to resident; -1650, 144G.70 Subd. 4. (f) Service plan, implementation, and revisions to service plan; -1730, 144G.71 Subd. 5. Individualized medication management plan; -1880, 144G.71 Subd. 19. Storage of medications; -1910, 144G.71 Subd. 22. Disposition of medications; -1940, 144G.72 Subd. 3. Individualized treatment or therapy management plan; and -2310, 144G.91 Subd. 4. (a) Appropriate care and services. On December 18, 2024, at 9:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was aware the licensee's plan of correction from the last survey only addressed the initial correction made on some of the orders, but not all, and she needed to improve upon making systematic process changes in her role that would impact future survey results. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		

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0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content, before executing an assisted living contract for two of two residents (R2, 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) 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	0 430		

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0 430	Continued From page 7 of the residents). The findings include: R2 R2 was admitted on February 5, 2023, and had diagnoses including vascular dementia (a type of dementia that occurs when blood flow to the brain is disrupted, damaging brain tissue and affecting memory, thinking, and behavior). R2's Residential Services Plan dated December 1, 2023, through November 30, 2024, indicated R2 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R2's medical record lacked an assisted living contract. R5 R5 was admitted on June 1, 2022, and had diagnoses including Alzheimer's disease (a brain disorder that progressively affects memory and thinking skills). R5's Services Plan dated June 1, 2022, indicated R5 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R5's medical record included a signed Resident Agreement dated June 1, 2022. R2 and R5's medical records lacked documentation they received a UDALSA, to include: -a disclosure of the categories of assisted living licenses available and the category of license held by the facility;	0 430		

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0 430	Continued From page 8 -a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license the facility does not provide; and -an oral explanation of the services offered under the contract. On December 18, 2024, at 8:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she did not have evidence of acknowledgement to show R2 and R5 received a UDALSA upon admission. The licensee's 1.04 Uniform Disclosure of Assisted Living Services policy dated August 1, 2021, included "5. The facility will obtain written acknowledgement from the resident or resident representative that [licensee] provided the UDALSA or document the reason why an acknowledgement was not obtained." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request 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;	0 460		

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0 460	Continued From page 9 (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week (24/7) for two of two residents (R2, 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 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 December 16, 2024, at 10:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they did not have a system for residents to summon staff assistance 24/7. LALD/CNS-A stated the licensee used a bed alarm system for resident safety which alerted the staff during the night to check on the resident.	0 460		

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0 460	Continued From page 10 R2 R2 had diagnoses including vascular dementia (a type of dementia that occurs when blood flow to the brain is disrupted, damaging brain tissue and affecting memory, thinking, and behavior). R2's Residential Services Plan dated December 1, 2023, through November 30, 2024, indicated R2 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R2's Uniform Assessment Tool dated September 5, 2024, noted to continue plan of care for R2 from initial registered nurse (RN) assessment (completed February 5, 2023). The assessment lacked documentation R2 was unable to properly utilize a system to request assistance from staff. R5 R5 had diagnoses including Alzheimer's disease (a brain disorder that progressively affects memory and thinking skills). R5's Services Plan dated June 1, 2022, indicated R5 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R5's Uniform Assessment Form dated June 1, 2022, noted to continue current plan of care for R5 from an initial RN assessment (completed June 1, 2023). The assessment lacked documentation R5 was unable to properly utilize a system to request assistance from staff. On December 19, 2024, at 10:40 a.m., during the exit conference, LALD/CNS-A stated she planned to update R2 and R5's assessment to include R2	0 460		

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0 460	Continued From page 11 and R5 were not able to accurately use a system to summon assistance due to dementia. The licensee's 2.01 24-Hour Emergency Response policy dated August 1, 2021, included "Residents living at [Licensee] have access to 24-hour emergency response by staff." Also, indicated "1. All residents/ representatives are given instructions on the use of emergency response system upon move in and ongoing, as needed. 2. An emergency cell phone will be carried at all times by a designated staff person. All emergency cell phones will be answered immediately. 3. The system will be tested on a regular basis, and no less than annually by the management staff of [Licensee]. 4. The emergency system is to be used for any emergency need." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently	0 480		

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0 480	Continued From page 12 enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480		

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0 480	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 16, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 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	0 510		

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0 510	Continued From page 14 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 and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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-C ULP-C was hired July 1, 2024, and provided direct care services to residents. On December 17, 2024, at 8:20 a.m., the surveyor observed ULP-C assist R5 with toileting and personal cares. Wearing gloves, ULP-C assisted R5 with peri cares, then without changing gloves and performing HH, ULP-C assisted R5 with setting up her toothbrush and performing oral care. Without removing gloves	0 510		

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0 510	Continued From page 15 and performing HH, ULP-C assisted R5 to walk to the dining room table for breakfast. The surveyor observed ULP-C touch the countertop, dining room chair, and medication lock box with soiled gloves. The surveyor then intervened and reminded ULP-C to perform HH. ULP-C completed HH appropriately with soap and water, and dried hands with paper towel. On December 17, 2024, at 8:43 a.m., ULP-C stated he was trained to complete HH between cares and glove changes but must have missed this because he was nervous being observed. ULP-D ULP-D was hired March 12, 2024, and provided direct care services to residents. On December 17, 2024, from 7:45 a.m., until 8:15 a.m., the surveyor observed ULP-D assisting residents with personal cares. ULP-D donned gloves while in the bathroom with R4, and assisted R4 to the toilet. First, ULP-D assisted R4 with changing her socks. Next, ULP-D doffed gloves, and retrieved a clean brief from the resident's room. Then, without performing HH, ULP-D donned gloves, and assisted R4 with dressing, grooming cares, then peri cares. After placing the clean brief, ULP-D doffed gloves. ULP-D instructed R4 to wash her hands, and ULP-D performed HH with soap and water briefly (approximately 5 seconds), and dried hands with a paper towel. On December 17, 2024, at 8:15 a.m., ULP-D stated she was trained to wash her hands for 30 seconds, and further stated she realized she had not washed her hands long enough during the observation.	0 510		

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0 510	Continued From page 16 On December 17, 2024, at 8:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff were trained to wash their hands between cares, between residents, and for at least 20 seconds. Also, LALD/CNS-A verbalized she planned to follow up more with the employees on handwashing. The Centers for Disease Control and Prevention (CDC) guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated standard precautions were to be used to care for all patients in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." The licensee's 8.09 Hand washing policy dated August 1, 2021. indicated, "Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: -Before, during, and after preparing food -Before eating food -Before and after caring for someone who is sick -Before and after treating a cut or wound -After using the toilet -After changing diapers or cleaning up after	0 510		

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LOVING CARE COTTAGE LLC	7740 HADLEY AVENUE SOUTH COTTAGE GROVE, MN 55016

(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 17 someone who has used the toilet -After blowing your nose, coughing, or sneezing -After touching an animal or animal waste -After handling pet food or pet treats -After touching garbage." In addition, the policy indicated "5. Use friction and scrub vigorously for at least 20 seconds". 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 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 and interview, the licensee failed to post the required information related to the grievance procedure, including the name,	0 550		

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0 550	Continued From page 18 telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential 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 December 16, 2024, at 11:07 a.m., the surveyor observed the common area in the main entry of the facility where the postings were located. The licensee lacked a posted grievance procedure with the current name, telephone number and email contact information for the individual who was responsible for handling resident grievances. On December 16, 2024, at 11:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the complaint posting contact information was not updated with the correct facility contact and had the previous owner's information; LALD/CNS-A planned to get the complaint contact information updated and posted. The licensee's 2.10 Complaint/Grievance Posting policy, dated August 1, 2021, indicated "1. [Licensee] will post, in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who	0 550		

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0 550	Continued From page 19 are responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, 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) 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	0 630		

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0 630	Continued From page 20 of the residents). The findings include: On December 16, 2024, from 12:15 p.m., through 12:45 p.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 and R5 with medication administration. R2 R2 was admitted on February 5, 2023, and had diagnoses including vascular dementia (a type of dementia that occurs when blood flow to the brain is disrupted, damaging brain tissue and affecting memory, thinking, and behavior). R2's Residential Services Plan dated December 1, 2023, through November 30, 2024, indicated R2 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R2's medical record lacked: -individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; and -the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R5 R5 was admitted on June 1, 2021, and had diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). R5's Services Plan dated June 1, 2022, indicated R5 received services including housekeeping, laundry, meals, dressing, grooming, bathing,	0 630		

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0 630	Continued From page 21 toileting, and medication administration. R5's medical record included a Uniform Assessment Form dated June 1, 2022. The assessment indicated R5 had memory loss, confusion, and poor decision making. R5's medical record included a Vulnerability/Abuse Prevention Plan, dated June 1, 2022. The form lacked R5's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. In addition, the form lacked an accurate assessment of R5's known vulnerabilities including: -Oriented to person, place, and time marked as "No." Additional information noted, "oriented x 1 (person)" -Able to report abuse/neglect/concerns marked as "Yes," despite being oriented only to person, and despite R5's June 1, 2022, assessment indicating memory loss, confusion, and poor decision-making. On December 18, 2024, at 8:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware of the required content for the resident IAPP. Additionally, LALD/CNS-A stated she agreed R5's IAPP was not accurate and commented she planned to update the residents' IAPPs with the required content. The licensee's 6.05 Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated "[Licensee] will develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults."	0 630		

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0 630	Continued From page 22 Additionally, indicated "1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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	0 650		

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0 650	Continued From page 23 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 maintain current records of each paid staff member, each regularly scheduled volunteer providing services, for two of four employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, and volunteer (V)-F). 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 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: LALD/CNS-A LALD/CNS-A was hired on May 1, 2021, and provided supervisory nursing services and direct nursing care for the licensee's residents. LALD/CNS-A lacked an employee record with the following required content: -records of orientation, required annual training and infection control training, and competency evaluations; -current job description; -documentation of annual performance reviews that identify areas of improvement needed and training needs; and	0 650		

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0 650	Continued From page 24 -verification that required health screenings under subdivision 9 have taken place and the dates of those screenings. V-F V-F provided weekly spiritual care services and administrative services for licensee since May 1, 2021. V-F lacked an employee record with the following required content: -records of orientation, required annual training and infection control training, and competency evaluations; -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; -documentation of annual performance reviews that identify areas of improvement needed and training needs; and -verification that required health screenings under subdivision 9 have taken place and the dates of those screenings. On December 17, 2024, at 10:15 a.m., LALD/CNS-A stated she did not think she needed an employee record for herself or V-F, but after surveyor educated LALD/CNS-A on the employee file requirements, understood why all employees and volunteers needed an employee record. The licensee's 4.05 Employee Records policy, dated August 1, 2021, indicated, "1. Employee records for each person will include: -Evidence of current professional licensure, registration, or certificate, if required -Records of all training and in-service education required and/or provided including record of competency testing as required -Current signed job description, which includes	0 650		

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0 650	Continued From page 25 qualifications, responsibilities, and identification of supervisors, if any -Documentation of annual performance reviews that identify areas of improvement needed and training needs -For individuals providing Assisted Living services, verification that required health screenings for Tuberculosis {TB) have taken place and the dates of those screenings. (recommended to keep medical information in a separate employee medical file) -Documentation of a competed criminal background study -Evidence that a reference check has been completed -Verification of completed orientation and annual training and competency testing as required. In addition, included "Employee records will be retained for at least three (3) years after an employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with [Licensee]." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must	0 660		

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0 660	Continued From page 26 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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included: TB baseline testing and TB transmission training for one of one volunteer (volunteer (V)-F); TB history and symptom screening for two of three employees/volunteer (unlicensed personnel (ULP)-D, and V-F). In addition, the licensee failed to complete a TB facility risk assessment annually, as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB Facility Risk Assessment dated March 1, 2022, indicated the facility was at low risk for TB transmission. The licensee lacked a TB risk assessment completed within the last	0 660		

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0 660	Continued From page 27 year. V-F On December 16, 2024, at 10:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, her mother volunteered at the facility weekly and provided spiritual care services for the residents since May 1, 2021. V-F lacked a record with documentation of baseline testing, TB history and symptom screen, and TB transmission training. ULP-D ULP-D was hired on March 12, 2024, and provided direct care assisted living services to licensee residents. On December 17, 2024, from 7:55 a.m., until 8:15 a.m., the surveyor observed ULP-D assist residents with personal cares. ULP-D's employee record included a negative QuantiFERON-TB Gold blood test, dated December 14, 2023. The record lacked documentation a history and symptom screening was completed. On December 17, 2024, at 9:13 a.m., LALD/CNS-A stated she was not able to find a completed a TB history and symptom screening for ULP-D. Also, LALD/CNS-A verbalized she was not aware the volunteer was required to complete a TB test, TB history and symptom screening, and TB transmission training but planned to get these required items completed. The Minnesota Department of Health (MDH) Assisted Living Resources and Frequently Asked	0 660		

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0 660	Continued From page 28 Questions website updated December 13, 2024 included under Tuberculosis Screening "Each facility must establish and maintain a comprehensive tuberculosis (TB) 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." Also, indicated "Each provider licensed by MDH is required to complete a TB risk assessment annually. Completion of this assessment will assist providers in the development of an infection control committee and in determining the frequency of screening." Additionally, noted "Baseline TB screening is required at the time of hire for all health care personnel in Minnesota." The licensee's 8.16 Tuberculosis Screening policy, dated August 1, 2021, indicated "Procedure: 2. The facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health." Also, included "Staff Screening, Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for	0 660		

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0 660	Continued From page 29 HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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0 680	Continued From page 30 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness and Fire Safety Program Manual dated February 16, 2022, included a "Review and update log - emergency preparedness program and missing resident plan" indicating the plan was last reviewed on March 1, 2022. The plan lacked evidence of the following requirements: -quarterly review of missing resident policy; -annual review of the emergency preparedness	0 680		

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0 680	Continued From page 31 plan policy; -emergency prep training program which includes maintain documentation of all EP training and EP training annually; and -emergency preparedness testing requirements. On December 16, 2024, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had an emergency preparedness plan but had not documented the Hazard Vulnerability Analysis (HVA) and EPP policies being reviewed annually. Also, LALD/CNS-A verbalized she was not aware the missing resident policy was to be reviewed quarterly. On December 18, 2024, at 9:10 a.m., LALD/CNS-A stated she did not have documentation of disaster drills with the employees. In addition, LALD/CNS-A verbalized she was not aware of the requirement to complete an annual full-scale exercise that is community based or conduct an annual individual, facility-based functional exercise. The licensee's 2.28 Missing Resident policy dated August 1, 2021, indicated, "[Licensee] will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented." The licensee's 9.02 Disaster Planning and Emergency Preparedness policy dated August 1, 2021, included, "On an annual basis, [Licensee] will make available training regarding emergency and disaster response to all residents of the facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

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	37940	A. BUILDING: _____ B. WING _____	12/19/2024

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0 680	Continued From page 32 (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been	0 730		

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0 730	Continued From page 33 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 that services were provided as identified in the service plan for two of two residents (R2, 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) 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: R2 R2 had diagnoses including vascular dementia (a type of dementia that occurs when blood flow to the brain is disrupted, damaging brain tissue and affecting memory, thinking, and behavior). R2's Residential Services Plan dated December 1, 2023, through November 30, 2024, indicated R2 received services including housekeeping,	0 730		

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0 730	Continued From page 34 laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R2's medical record included a Resident Plan of Care dated November 1, 2024, November 7, 2024, November 14, 2024, November 21, 2024, November 28, 2024, December 1, 2024, and December 7, 2024, initialed by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A weekly which documented R2 received the following services: -medication administration four times daily and as needed; -shower assist once per week; -activities of daily living (ADLs) twice daily and as needed; -dressing assist twice daily and as needed; -toileting assist five to seven times per day and as needed; -incontinence assistance as needed; -personal laundry twice daily; -housekeeping three times daily -linen wash once per week; -food preparation three times daily and snacks; -vital signs monitoring once per week; -overnight monitoring three times per night; -group and individual activities three to five times daily; -ambulation assist eight to twelve times daily; -behavior interventions and redirect six to eight times daily; -pressure sensitive mat every day at bedtime; -nail care assistance one to two times per week; -fluid reminder eight to twelve times daily; -peri cares twice daily and as needed; -transfer belt with all ambulation; -safety belt when in wheelchair; -tab alarm when in recliner; and -reposition every two hours as needed.	0 730		

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0 730	Continued From page 35 R2's service delivery records lacked documentation of who provided the services and at what time the service was provided. R5 R5 had diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). R5's Services Plan dated June 1, 2022, indicated R5 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R5's medical record included a Resident Plan of Care that indicated, "Initial after services received," dated November 1, 2024, November 7, 2024, November 14, 2024, November 21, 2024, November 28, 2024, December 1, 2024, and December 7, 2024, initialed by the licensed assisted living director/clinical nurse supervisor weekly which documented R5 received the following services: -medication administration four times daily and as needed; -shower assist once per week; -ADLs twice daily and as needed; -dressing assist twice daily and as needed; -toileting/incontinence assist five to seven times daily; -personal laundry twice daily; -housekeeping three times daily -linen wash once per week; -food preparation three times daily and snacks; -vital signs monitoring once per week; -overnight monitoring three times per night; -group and individual activities three to five times daily; -ambulation assist eight to twelve times daily as needed;	0 730		

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0 730	Continued From page 36 -transfer belt with all ambulation; -behavior interventions and redirect five to seven times daily; -pressure sensitive mat every day at bedtime; -nail care assistance one time per week; -fluid reminder eight to twelve times daily; and -peri cares twice daily and as needed. R5's service delivery records lacked documentation of who provided the services and at what time the service was provided. On December 17, 2024, at 9:45 a.m., LALD/CNS-A stated the residents' services provided were not documented daily by the caregiver, and LALD/CNS-A documented her initial weekly on the Resident Plan of Care. Also, LALD/CNS-A verbalized she was not aware the services provided to the resident needed to be completed daily by the caregiver who provided the service. Finally, LALD/CNS-A stated she planned to update the process for the documentation of resident services. The licensee's 2.37 Resident Record - Documentation policy dated August 1, 2021, indicated, "Staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to resident. All documentation must include the signature and title of the person who performed the service or administered the medication, treatment, or therapy. Initials may be used if there is a completed signature page included in the documentation." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 comply with the current Minnesota Fire Code provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 780		

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0 780	Continued From page 38 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 a facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-E on December 17, 2024, from 11:00 a.m. to 1:00 p.m., the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions. Washer and Dryer plugged into a power tap. Power tap was not listed and could cause cause an overload of the electrical outlet. Washers and dryers should be plugged directly into a wall outlet or a UL listed power supply adapter. This deficient condition was visually verified by LALD/CNS-A accompanying on the tour. On December 18, 2024, at 12:30 p.m., LALD/CNS-A and O-E stated they understood requirements. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and	0 790		

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0 790	Continued From page 39 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On a facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-E on December 17, 2024, from 11:00 a.m. to 1:00 p.m., it was observed that the required fire extinguisher near the kitchen panty was mounted, higher than 60 inches above the floor. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a	0 790		

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0 790	Continued From page 40 certified technician. On December 18, 2024, at 12:00 p.m., LALD/CNS-A and O-E, verified this deficient finding. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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) staff 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) Staff 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 staff twice per year per shift with at least one evacuation drill	0 810		

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0 810	Continued From page 41 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, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 18, 2024, from 11:00 a.m. to 1:00 p.m., the surveyor observed the posted evacuation plans and sleeping rooms lacked identification of resident rooms. On December 17, 2024, at, 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. RESIDENT ACTIONS The FSEP did not identify specific fire protection	0 810		

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0 810	Continued From page 42 actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan did not include instructions to evacuate residents or include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On December 18, 2024, at 12:30 p.m., LALD/CNS-A and O-E stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was a provider made policy that was not specific to the facility. TRAINING The licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-A and O-E lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On December 18, 2024, at 12:30 p.m., LALD/CNS-A and O-E stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at	0 810		

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0 810	Continued From page 43 least one evacuation drill every other month. No other documentation was provided. On December 4, 2024, at 3:30 p.m., LALD/CNS-A and O-E stated would give verbal training classes but provided no documented drills for the facility. LALD/CNS-A and O-E stated they understood the requirements for evacuation drills for staff and would implement an evacuation program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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 a staff member 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 obtain a cleared Minnesota	01290		

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01290	Continued From page 44 Department of Human Services (DHS) background study clearance prior to providing services for one of one volunteer staff (volunteer (V)-F). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 16, 2024, at 10:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated her mother, V-F, provided weekly spiritual care services for the residents. LALD/CNS-A stated V-F also assisted her with administrative tasks. V-F lacked an employee record and lacked evidence of a cleared background study on the DHS Net Study 2.0 Roster. On December 17, 2024, at 9:45 a.m., LALD/CNS-A stated a background study was not completed for V-F prior to providing spiritual care services and assisting with administrative tasks. LALD/CNS-A also stated, "it makes sense she would need a background check, but it was not completed." -at 10:45 a.m., LALD/CNS-A stated V-F had volunteered at the facility since May 1, 2021. The licensee's Background Studies policy dated	01290		

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01290	Continued From page 45 August 1, 2021, indicated "[Licensee] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [Licensee]. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [Licensee] will not employ individuals whose results of the background study indicate disqualification for the position. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them;	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37940	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE COTTAGE LLC	7740 HADLEY AVENUE SOUTH COTTAGE GROVE, MN 55016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 46 (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed with all required content for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 December 16, 2024, at 10:15 a.m., during the entrance conference, licensed assisted living	01370		

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01370	Continued From page 47 director/clinical nurse supervisor (LALD/CNS)-A stated initial training and competency was provided by LALD/CNS-A. Also, LALD/CNS-A verbalized she used the Advanced Health Institute training manual provided by Care Providers of Minnesota and through hands-on learning, then she would assess competency. On December 17, 2024, from 7:45 a.m., until 8:43 a.m., the surveyor observed ULP-C and ULP-D assist residents with personal cares. ULP-C ULP-C was hired on July 1, 2024, to provide direct care services to residents of the assisted living facility. ULP-C's employee record lacked documentation of training and competency evaluations for ULP providing assisted living services including: -appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; and -awareness of commonly used health technology equipment and assistive devices. ULP-D ULP-D was hired on March 12, 2024, to provide direct care services to residents of the assisted	01370		

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01370	Continued From page 48 living facility. ULP-D's employee record lacked documentation of training and competency evaluations for ULP providing assisted living services including: -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; and -awareness of commonly used health technology equipment and assistive devices. On December 18, 2024, at 9:21 a.m., LALD/CNS-A stated she must have missed completing some of this training and competency with ULP-C and ULP-D or she did not document the training. In addition, LALD/CNS-A verbalized she planned to make sure all caregiver training was completed and documented. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated "1. A Registered Nurse (or other licensed health professional where appropriate) will determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel. 2. Only unlicensed personnel who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. 3. The Assisted Living facility will have a system in place to communicate up-to-date information to a RN regarding current available staff and their competencies. 4. Training and competency evaluations of ULPs will be conducted by a RN, or another instructor may provide the training in conjunction with a RN. 5. Training and competency evaluations for all ULPs will include:	01370		

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01370	Continued From page 49 a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the facility c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional k) Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family l) awareness of confidentiality and privacy m) Understanding appropriate boundaries between staff and residents and the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment and assistive devices." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01380	Continued From page 50	01380		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluation was completed with all required content for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01380		

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01380	Continued From page 51 On December 16, 2024, at 10:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated initial training and competency was provided by LALD/CNS-A. Also, LALD/CNS-A verbalized she used the Advanced Health Institute training manual provided by Care Providers of Minnesota and through hands-on learning, then she would assess competency. On December 17, 2024, from 7:45 a.m., until 8:43 a.m., the surveyor observed ULP-C and ULP-D assist residents with personal cares. ULP-C ULP-C was hired on July 1, 2024, to provide direct care services to residents of the assisted living facility. ULP-C's employee record lacked documentation of training and competency evaluations for ULP providing assisted living services including: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required. ULP-D ULP-D was hired on March 12, 2024, to provide direct care services to residents of the assisted living facility. ULP-D's employee record lacked documentation of training and competency evaluations for ULP providing assisted living services including: -administering medications or treatments as required.	01380		

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01380	Continued From page 52 On December 18, 2024, at 9:21 a.m., LALD/CNS-A stated she must have missed completing some of the training and competency with ULP-C and ULP-D, or she did not document the training. In addition, LALD/CNS-A verbalized she planned to make sure all caregiver training was completed and documented. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated "6. In addition to the above training and competency evaluation for unlicensed personnel providing assisted living services must include: a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning g. Administering medications or treatments as required." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an	01440		

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01440	Continued From page 53 appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01440		

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01440	Continued From page 54 The findings include: On December 16, 2024, at 12:15 p.m., the surveyor observed ULP-C assist R2 and R5 with medication administration. ULP-C and ULP-D were hired on July 1, 2024, and March 12, 2024, respectively, to provide direct care services to residents of the assisted living facility. ULP-C and ULP-D's employee record included a 30-day Staff Performance Review dated October 8, 2024, and April 4, 2024, respectively, but lacked documentation of 30-day supervision to include observation of the staff administering the medication or treatment and the interaction with the resident. On December 18, 2024, at 9:18 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was responsible to make sure all caregiver training was completed. LALD/CNS-A stated she thought she completed a 30-day supervision for ULP-C, but it was not documented. Also, LALD-CNS-A verbalized she was unable to find a 30-day supervision of a delegated task for ULP-D and stated, "if it's not documented it's not done." The licensee's 6.17 Supervision of Staff - Delegated Services policy, dated August 1, 2021, indicated "1. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [Licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance. 2. This requirement also applies to staff that have	01440		

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01440	Continued From page 55 not performed delegated tasks for one (1) year or longer. 3. The supervision should be through the direct and indirect observation of the unlicensed personnel performing the services. The resident or resident's responsible person may be interviewed to assure they are satisfied with the services they are receiving. 4. It is the responsibility of the RN staff to ensure the supervision is done within the time frames outlined above and specified on the client's service plan. 5. Documentation of supervision activities will be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	01530		

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01530	Continued From page 56 dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for two of two employees, (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 December 17, 2024, from 7:45 a.m., until 8:43 a.m., the surveyor observed ULP-C and ULP-D assist residents with personal cares. ULP-C and ULP-D were hired July 1, 2024, and March 12, 2024, respectively, to provide direct care services. ULP-C, and ULP-D's employee records included three hours of dementia care training, five hours	01530		

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01530	Continued From page 57 less than the required eight hours of dementia care training completed within 160 hours of the employment start date. The training for both ULP-C and ULP D lacked training on the topic of problem solving with challenging behaviors. On December 18, 2024, at 9:18 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she did not have any additional dementia care training documented for ULP-C or ULP-D. LALD/CNS-A verbalized she completed all the dementia utilizing a hands-on approach for training, but the full eight hours of training was not documented. On December 19, 2024, at 10:40 a.m., LALD/CNS-A stated she is responsible for the employees training, and she planned to improve on her documentation of the employee training completed. The licensee's 3.01 ALDC Additional Dementia Staff Training policy dated June 2021, indicated, "2. Training will be documented and will indicate staff knowledge and understanding of such training." The policy also included, "5. Staff Training. a. Staff will be trained to provide a person-centered care approach. b. All direct care staff assigned to provide care for residents with dementia will be trained to work with residents with Alzheimer's disease and other dementias. c. Staff training will include the following topics: i. Understanding cognitive impairment, and behavioral and psychological symptoms of dementia; and ii. Standards of dementia care, including nonpharmacological dementia care practices that are person- centered and evidence informed."	01530		

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01530	Continued From page 58 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and	01620		

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01620	Continued From page 59 reassessment, utilizing a uniform assessment tool, no more than 14 days after admission for one of two residents (R2), and not more than 90 days from the previous assessment for two of two residents (R2, 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) 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 December 16, 2024, at 10:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee completed nursing assessments upon admission, within 14 days of admission, every 90 days, and with a change in condition. R2-14-DAY/90-DAY REASSESSMENT R2 was admitted on February 5, 2023, and received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R2's medical record included a comprehensive RN assessment, dated February 20, 2023, greater than 14-days after start of services. R2's medical record included a comprehensive RN assessment, dated September 4, 2024, but lacked any subsequent assessments as of the date of the survey (greater than 90 days after).	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37940	A. BUILDING: _____ B. WING _____	12/19/2024

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01620	Continued From page 60 R5-90-DAY REASSESSMENT R5 was admitted June 1, 2022, and received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R5's medical record included a comprehensive RN assessment, dated June 1, 2023, but lacked any subsequent assessments as of the date of the survey (greater than 90 days after). On December 18, 2024, at 9:40 a.m., LALD/CNS-A stated she was behind on the resident assessments. LALD/CNS-A also stated if R2 and R5's assessments were late she either did not complete them or did not document the assessment. The licensee's 6.01 Assessments, Reviews and Monitoring of Clients-Initial policy, dated August 1, 2021, indicated, "3. 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." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 61 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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	01640		

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01640	Continued From page 62 pervasive). The findings include: R2 R2 was admitted on February 5, 2023, and had diagnoses including vascular dementia (a type of dementia that occurs when blood flow to the brain is disrupted, damaging brain tissue and affecting memory, thinking, and behavior). R2's medical record included an elderly waiver Residential Services Plan dated December 1, 2023, through November 30, 2024, indicated R2 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R3 R3 was admitted on April 8, 2023, and had diagnoses including vascular dementia. R3's medical record included an elderly waiver Support Plan dated October 24, 2024, through September 30, 2025, indicated R3 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R2 and R3's medical records lacked a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. On December 16, 2024, at 2:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she used the Residential Services Plan and Support Plan completed by R2 and R3's county case worker as the licensee's service plan. LALD/CNS-A also verbalized she	01640		

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01640	Continued From page 63 also used the licensee's Resident Plan of Care where services received were documented weekly as part of the resident's service plan. LALD/CNS-A stated these documents were not authenticated by R2 and R3, or the resident representatives. The licensee's 6.08 Service Plans policy dated August 1, 2021, included "1. Within 14 days after the date that services are first provided to a resident, [Licensee] will finalize a written service plan. 2. The service plan and any revisions shall include a signature or other authentication by [Licensee]and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	01650		

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01650	Continued From page 64 (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for three of three residents (R2, R3, 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) 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: R2 R2 was admitted on February 5, 2023, and had diagnoses including vascular dementia (a type of dementia that occurs when blood flow to the brain is disrupted, damaging brain tissue and affecting memory, thinking, and behavior).	01650		

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01650	Continued From page 65 R2's medical record included an elderly waiver Residential Services Plan dated December 1, 2023, through November 30, 2024, and a Resident Plan of Care for December 2024, which indicated R2 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R2's record lacked a service plan with the following requirements: -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3 R3 was admitted on April 8, 2023, and had diagnoses including vascular dementia. R3's medical record included an elderly waiver	01650		

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01650	Continued From page 66 Support Plan dated October 24, 2024, through September 30, 2025, and a Resident Weekly Service Plan for November 2024, which indicated R3 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R3's record lacked a service plan with the following requirements: -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R5 R5 was admitted on June 1, 2021, and had diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). R5's Services Plan dated June 1, 2022, indicated	01650		

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01650	Continued From page 67 R5 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R5's Services Plan dated June 1, 2022, lacked the following information: -a contingency plan that includes; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On December 16, 2024, at 2:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she used the Residential Services Plan and Support Plan completed by R2 and R3's county case worker for the licensee's service plan. LALD/CNS-A also verbalized she also used the licensee's Resident Plan of Care where services received were documented weekly as part of the resident's service plan. LALD/CNS-A was not aware of the required content to be included with the service plan. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated, "9. A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and	01650		

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01650	Continued From page 68 resident preferences d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes: i. Actions Loving Care Cottage LLC will take if scheduled services cannot be provided ii. Information regarding how the resident can contact Loving Care Cottage LLC iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency v. How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01710 SS=F	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.	01710		

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01710	Continued From page 69 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment at least annually for two of two residents (R2, R5) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 had diagnoses including vascular dementia (a type of dementia that occurs when blood flow to the brain is disrupted, damaging brain tissue and affecting memory, thinking, and behavior). R2's Residential Services Plan dated December 1, 2023, through November 30, 2024, indicated R2 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R2's Uniform Assessment Tool dated February 5, 2023, indicated on page 15, "Resident is deemed UNABLE to safely self-administer medications for the following reason(s): severe cognitive impairment."	01710		

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01710	Continued From page 70 R5 R5 was admitted on June 1, 2021, and had diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). R5's Services Plan dated June 1, 2022, indicated R5 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R5's medical record included a Medication Assessment Form dated May 27, 2022, and a Uniform Assessment tool dated September 1, 2023. On December 16, 2024, at 12:15 p.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 and R5 with medication administration. R2, and R5's medical records lacked an annual reassessment of the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. On December 17, 2024, at 10:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware there was a requirement to complete a medication assessment annually at a minimum. Also, LALD/CNS-A verbalized if R2 and R5's assessment did not have an update annually then it was not completed. The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated "[Licensee] will monitor and reassess the resident's medication	01710		

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01710	Continued From page 71 management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication	01730		

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01730	Continued From page 72 management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for two of two residents (R2, 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 16, 2024, at 12:15 p.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 and R5 with medication administration. R2	01730		

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01730	Continued From page 73 R2 had diagnoses including vascular dementia (a type of dementia that occurs when blood flow to the brain is disrupted, damaging brain tissue and affecting memory, thinking, and behavior). R2's Residential Services Plan dated December 1, 2023, through November 30, 2024, indicated R2 received services including housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R2's Uniform Assessment Tool dated February 5, 2023, indicated on page 15, "Resident is deemed UNABLE to safely self-administer medications for the following reason(s): severe cognitive impairment." R2's medical record lacked an individualized medication management plan with the following required content including: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. R5 R5 had diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). R5's Services Plan dated June 1, 2022, indicated R5 received services including housekeeping,	01730		

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	37940	A. BUILDING: _____ B. WING _____	12/19/2024

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LOVING CARE COTTAGE LLC	7740 HADLEY AVENUE SOUTH COTTAGE GROVE, MN 55016

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01730	Continued From page 74 laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R5's medical record included a Medication Assessment Form dated May 27, 2022, but lacked an individualized medication management plan with the following required content including: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On December 18, 2024, at 8:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware of the required content to be included in the medication assessment and individualized medication management plan for the residents who received medication administration assistance. Also, LALD/CNS-A stated, "I haven't documented all I do for the residents and need to get better at this." The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated "For each resident at [Licensee] medication management services, the facility will prepare and include in the service plan a written statement of the medication management services that will be provided to the resident." Also, included [Licensee] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided;	01730		

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01730	Continued From page 75 b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; c. Documentation of specific resident instructions relating to the administration of medications; d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; e. Identification of medication management tasks that may be delegated to unlicensed personnel; f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01770		

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01770	Continued From page 76 review, the licensee failed to document all required content for medication set up for two of two residents (R2, 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 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: R2 R2 had diagnoses including vascular dementia (a type of dementia that occurs when blood flow to the brain is disrupted, damaging brain tissue and affecting memory, thinking, and behavior). R2's Residential Services Plan dated December 1, 2023, through November 30, 2024, indicated R2 received services including medication administration. R5 R5 had diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). R5's Services Plan dated June 1, 2022, indicated R5 received services including medication administration. R2 and R5's medical record lacked documentation at the time of medication setup to include: -the dates of medication setup;	01770		

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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
01770	Continued From page 77 -name of medication; -quantity of dose; -times to be administered; -route of administration; and -name of person completing medication setup. On December 16, 2024, at 10:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she completed medication set up weekly for all the licensee's residents. On December 16, 2024, at 12:15 p.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 and R5 with medication administration. In addition, the surveyor noted six mediset (pill organizer) boxes located in the unlocked medication box in the kitchen area. On December 17, 2024, at 10:35 a.m., LALD/CNS-A stated she did not document the residents' weekly medication set up, but planned to implement a documentation process. The licensee's 7.08 Medication Management - Administration & Setup policy dated August 1, 2021, indicated, "The nursing staff and unlicensed personnel trained to provide medication administration at [Licensee] will document any medication administration provided accurately in each resident record. A licensed nurse will correctly and accurately document any medication setup provided." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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01880	Continued From page 78	01880		
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 facility failed to store all prescription medications in securely locked and substantially constructed compartment according to the manufacturer's directions and permit only authorized personnel to have access for two of two residents (R2, 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) 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 December 16, 2024, at 10:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee stored the resident medications in locked medication boxes located in the kitchen area on the main floor of the facility. R2 R2 had diagnoses including vascular dementia (a type of dementia that occurs when blood flow to the brain is disrupted, damaging brain tissue and	01880		

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01880	Continued From page 79 affecting memory, thinking, and behavior). R2's Residential Services Plan dated December 1, 2023, through November 30, 2024, indicated R2 received services including assistance with housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. R2's medical record included signed provider orders dated April 3, 2024, with an order for licensee to administer morphine (for pain) 5 milligrams (mg), four times daily. R2's medical record included a Medication Administration Record (MAR) dated December 1, 2024, through December 16, 2024. The MAR indicated R2 was administered morphine 5 mg, one tablet orally four times daily, 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. R5 R5 had diagnoses including Alzheimer's disease (a brain disorder that progressively reduces memory and thinking skills). R5's Services Plan dated June 1, 2022, indicated R5 received services including assistance with housekeeping, laundry, meals, dressing, grooming, bathing, toileting, and medication administration. On December 16, 2024, at 12:15 p.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 and R5 with medication administration. R2 and R5 were seated at the dining room table as lunch was served. Two medication storage boxes with code locks were affixed under the upper cabinet in the kitchen dining area. There were six medication set up containers observed	01880		

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01880	Continued From page 80 in the left-side medication box, which was unlocked. ULP-C retrieved both R2 and R5's mediset containers from the left-side, unlocked medication box. ULP-C dispensed R2's medications from the mediset container, and verified R2's morphine was one of the medications present in the container. On December 16, 2024, at 12:25 p.m., ULP-C stated the left medication box was used for storage of the residents' medication set up containers and the lock had been broken "for a while now", with no specific number of days given. On December 16, 2024, at 12:45 p.m., LALD/CNS-A stated she knew the medications needed to be locked and had not had the opportunity to get the medication lock box fixed. LALD/CNS-A further stated she may need to call a locksmith to have the lock fixed. LALD/CNS-A removed the medication set up containers from the left-side medication box and placed them into the right-side medication box where the code lock operated correctly. In addition, LALD/CNS-A stated she set up all medications, including narcotics for residents, during the weekly medication set up and LALD/CNS-A verbalized she completed narcotic counts weekly with medication set up. The licensee's 7.11 Medication Storage policy, revised August 1, 2021, indicated, "When medications are managed and stored by [Licensee], medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications." Also, included "Medications managed outside of a resident's private "living space" must be in securely locked and	01880		

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01880	Continued From page 81 substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the 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 four of five residents (R2, R3, R4, R5) who utilized hospital style bed rails. 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:	02310		

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02310	Continued From page 82 On December 16, 2024, at 11:07 a.m., the surveyor observed the bedrooms of the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. R2, R4 and R5's shared bedroom included three hospital style beds with bilateral (both sides) upper side rails. R3's private bedroom included a hospital style bed with bilateral upper side rails. R2 R2 was admitted on February 5, 2023, and had diagnoses which included vascular dementia. R2's medical record included a Residential Service Plan dated December 1, 2023. R2's medical record lacked: -side rail use assessment; -documentation of measurements of zones of entrapment; and -documentation of discussion of risks vs. benefits of side rail use. R3 R3 was admitted on April 18, 2023, and had diagnoses which included vascular dementia. R3's medical record included a Support Plan dated November 25, 2024. R3's medical record included a Siderail/Tab Alarm Use Assessment Form dated April 8, 2023. R3's medical record lacked documentation of measurements of zones of entrapment. R4 R4 was admitted on December 7, 2023, and had diagnoses which included dementia.	02310		

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02310	Continued From page 83 R4's medical record included a Residential Service Plan dated June 27, 2023. R4's medical record lacked: -side rail use assessment; -documentation of measurements of zones of entrapment; and -documentation of discussion of risks vs. benefits of side rail use. R5 R5 was admitted on June 1, 2022, and had diagnoses which included Alzheimer's disease. R5's Service Plan dated June 1, 2022, indicated R5 required assistance with bathing, laundry, housekeeping, dressing, grooming, toileting, ambulation, overnight monitoring, and medication administration. R5's medical record included a Siderail/Tab Alarm Use Assessment Form dated June 1, 2022. R5's medical record lacked documentation of measurements of zones of entrapment. On December 16, 2024, at 1:39 p.m., the surveyor observed the main floor of the facility with unlicensed personnel (ULP)-B. R2, R4, and R5 shared a bedroom. R2's hospital style bed had bilateral upper side rails, both in the upright positions. R4's hospital style bed had bilateral upper side rails, the left side rail in the upright position, and the right side rail in the downward position. R5's hospital style bed had bilateral upper side rails, the right side rail in the upright position, and left side rail in the downward position. R3's private bedroom included a hospital style bed had bilateral upper side rails, the left	02310		

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02310	Continued From page 84 side rail in the upright position, and right side rail in the downward position. On December 16, 2024, at 1:50 p.m., LALD/CNS-A stated R2, R3, and R4 received elderly waiver services and the licensee used the Residential Services Plan as the residents' service plans. Also, LALD/CNS-A verbalized she did not complete measurements of the side rail zones of entrapment as required for R2, R3, R4, and R5. On December 16, 2024, at 2:50 p.m., LALD/CNS-A stated the licensee provided all daily personal cares and medication administration for R2, R3, and R4. The licensee's 6.28 Side rails policy dated August 1, 2021, included "1. When side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. If the side rail is acting as a restraint, appropriate action should be taken." Also, indicated "1. Staff from [Licensee] will determine if the side rail is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below: a. The side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. c. The side rail design is consistent with the FDA's [Food and Drug Administration] 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4.75"."	02310		

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02310	Continued From page 85 The FDA's A Guide to Bed Safety, dated March 10, 2006, 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 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 Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 12, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's	02310		

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02310	Continued From page 86 guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Type: Full
Date: *12/16/24*
Time: 12:30:17
Report: 1004241221

Food and Beverage Establishment Inspection Report

Location:
Loving Care Cottage Llc
7740 Hadley Avenue South
Cottage Grove, MN55016
Washington County, 82

Establishment Info:
ID #: 0039253
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122240528
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

ESTABLISHMENT DOES NOT USE AN EMPLOYEE ILLNESS LOG. ALL EMPLOYEE REPORTS OF ILLNESS/SYMPTOMS THAT CAN BE SPREAD THROUGH FOOD MUST BE RECORDED ON AN EMPLOYEE ILLNESS LOG. *LOG PROVIDED WITH REPORT.

Comply By: 12/16/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR FOR USE WITH THE HIGH TEMP. SANITIZING DISH MACHINE. PROVIDE AND USE FREQUENTLY TO ENSURE A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160*F IS REACHED FOR SANITIZING.

Comply By: 12/16/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

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

NO SANITIZER TEST STRIPS/KIT FOR USE WITH CHLORINE BLEACH SANITIZER. PROVIDE AND USE FREQUENTLY TO ENSURE A CONCENTRATION OF 50-100PPM IS USED FOR SANITIZING.

Comply By: 12/16/24

Type: Full
Date: *12/16/24*
Time: 12:30:17
Report: 1004241221
Loving Care Cottage Llc

Food and Beverage Establishment Inspection Report

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.115AB ***** Priority 2 *****

MN Rule 4626.1585AB Remove all live animals from the establishment except as specified in rule.

ESTABLISHMENT HAS A RESIDENT DOG AND CAT THAT HAVE ACCESS TO KITCHEN. RESTRICT ANIMAL ACCESS TO KITCHEN.

Comply By: 12/16/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Chlorine: = 200PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: HOT DOG
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: <40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY DEDE HINNENDAEL.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE OPERATOR, CHARITY, AND WITH THE NURSE EVALUATOR, DEDE.

Food and Beverage Establishment Inspection Report

*FLOORS ARE HARDWOOD AND CEILING IS "POPCORN" TEXTURE. COUNTERTOPS ARE LAMINATE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

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*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 1004241221 of 12/16/24.

Certified Food Protection Manager: DEREK WEINREICH

Certification Number: FM109602 Expires: 02/07/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
CHARITY VAILLANCOURT

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us