Electronically delivered

September 19, 2022

Administrator
Bridges Of Zumbrota
295 West 4th Street
Zumbrota, MN 55992

RE: Project Number(s) SL20583015

Dear Administrator:

On September 13, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on June 16, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the June 16, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on June 16, 2022, found not corrected at the time of the September 13, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 = $500

The details of the violations noted at the time of this follow-up evaluation completed on September 13, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

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

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

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20583	A. BUILDING: _____ B. WING _____	R 09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES OF ZUMBROTA	295 WEST 4TH STREET ZUMBROTA, MN 55992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20583015-1 On September 13, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on June 16, 2022. At the time of the survey, there were 10 residents; 8 receiving services under the Assisted Living license. As a result of the revisit, the following correction order was reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions	{0 250}		

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{0 250}	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	{0 250}		

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{0 250}	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: No further action required.	{0 250}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake;	{0 470}		

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{0 470}	Continued From page 3 (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that one or more employees were available to respond to the requests of residents for assistance with health or safety needs 24 hours per day seven days per week. 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: The licensee's Census-Staff Analysis dated August 10, 2022, indicated the licensee would have an unlicensed personnel (ULP) 24 hours per day in the facility to provide assistance with health or safety needs of the residents. In addition, the ULP would be from Bridges of Zumbrota or Zumbrota Health Services. The untitled staff schedule dated September 11, 2022, indicated from August 28, 2022, to	{0 470}		

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{0 470}	Continued From page 4 September 13, 2022, nursing home employees from an attached building were utilized for the licensee's overnight shift on seven occasions. On September 13, 2022, at 9:26 a.m., registered nurse (RN)-H stated the licensee used the staff model listed in the plan of correction. In addition, RN-H stated one ULP was scheduled every shift, the RN worked 40 hours per week and was on call 24-hours per day, and the RN was the replacement if a ULP called in sick for a shift. On September 13, 2022, at 9:54 a.m., licensed assisted living director (LALD)-A provided the surveyor with an email correspondence dated August 16, 2022, that contained a request to the Minnesota Department of Health (MDH) for a new rule variance to utilize the nursing home employees in the attached building for the assisted living facility on the overnight shift. LALD-A stated the licensee had not received information if the variance request was approved by MDH. On September 13, 2022, at approximately 9:56 a.m., RN-H stated "NH" on the staff schedule indicated a nursing home employee was assisting the assisted living facility by responding to resident call lights as needed. On September 13, 2022, at 10:19 a.m., LALD-A stated the nursing home employees that responded to call lights in the assisted living facility had received assisted living training. The licensee Staffing policy dated August 1, 2021, read "Clinical Nurse Supervisor (CNS) will develop and implement a written staffing plan that provides an adequate number of qualified, awake direct-care staff to meet the resident's needs	{0 470}		

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{0 470}	Continued From page 5 24-hours a day, seven-days a week. When developing the staffing plan, the CNS will ensure that staffing levels are adequate to address the following: a. Each resident's needs, as identified in the resident's service plan and assisted living contract; b. Each resident's acuity level as determined by the most recent assessment or individualized review; c. The ability of staff to timely meet the resident's scheduled and reasonable foreseeable unscheduled needs given the physical layout of the care center premises". No other information was provided.	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced	{0 480}		

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{0 480}	Continued From page 6 by: No further action required.	{0 480}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: No further action required.	{0 550}		
{0 620} SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: No further action required.	{0 620}		

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{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an 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: No further action required.	{0 630}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs;	{0 650}		

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{0 650}	Continued From page 8 (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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: No further action required.	{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	{0 660}		

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{0 660}	Continued From page 9 by: No further action required.	{0 660}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required.	{0 780}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	{0 810}		

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{0 810}	Continued From page 10 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the	{0 930}		

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{0 930}	Continued From page 11 facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: No further action required.	{0 930}		
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b);	{0 940}		

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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
{0 940}	Continued From page 12 (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: No further action required.	{0 940}		
{0 970} SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	{0 970}		

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{0 970}	Continued From page 13 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action required.	{0 970}		
{01370} SS=D	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; (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	{01370}		

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{01370}	Continued From page 14 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: No further action required.	{01370}		
{01380} SS=D	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: No further action required.	{01380}		

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

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{01470}	Continued From page 16 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required.	{01470}		
{01530} SS=D	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	{01530}		

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{01530}	Continued From page 17 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: No further action required.	{01530}		
{01620} SS=D	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	{01620}		

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{01620}	Continued From page 18 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: No further action required.	{01620}		
{01640} SS=D	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. (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: No further action required.	{01640}		

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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: No further action required.	{01650}		
{01710} SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and	{01710}		

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{01710}	Continued From page 20 reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: No further action required.	{01710}		
{01730} SS=D	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	{01730}		

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{01730}	Continued From page 21 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: No further action required.	{01730}		
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: No further action required.	{01750}		

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{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action required.	{01760}		
{01770} SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: No further action required.	{01770}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed	{01790}		

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{01790}	Continued From page 23	{01790}		

nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;
(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and
(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of

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{01790}	Continued From page 24 medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: No further action required.	{01790}		
{01910} SS=E	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the	{01910}		

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{01910}	Continued From page 25 medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action required.	{01910}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent	{01940}		

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{01940}	Continued From page 26 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action required.	{01940}		
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: No further action required.	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20583	A. BUILDING: _____ B. WING _____	R 09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES OF ZUMBROTA	295 WEST 4TH STREET ZUMBROTA, MN 55992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{03000}	Continued From page 27	{03000}		
{03000} SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should	{03000}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES OF ZUMBROTA	**295 WEST 4TH STREET ZUMBROTA, MN 55992**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{03000}	Continued From page 28 determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: No further action required.	{03000}		

Electronically Delivered

July 27, 2022

Administrator
Bridges Of Zumbrota
295 West 4th Street
Zumbrota, MN 55992

RE: Project Number SL20583015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 16, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 imposed immediately with no opportunity to correct the violation first as follows:

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

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

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

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00

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

The total amount you are assessed is $6,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20583	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES OF ZUMBROTA	295 WEST 4TH STREET ZUMBROTA, MN 55992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL#20583015 On June 13, 2022, through June 16, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there 14 residents, of which 8 residents were receiving services under the provider's Assisted Living license. On June 15, 2022, the immediacy of correction orders 0470 and 2310 has been removed; however, non-compliance remains at a scope and level level 3, widespread (I).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the	0 250		

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 13, 2022, at approximately 10:44 a.m., registered nurse (RN)-C and RN-B stated the licensee's employees in charge of the facility were familiar	0 250		

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0 250	Continued From page 3 with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets	0 250		

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0 250	Continued From page 4 requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all	0 250		

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0 250	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by authorized agent (AA)-G on May 10, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: -requirements in section 626.557, reporting of maltreatment of vulnerable adults; -orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; -implementation of the assisted living bill of rights; -conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; -conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with	0 250		

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0 250	Continued From page 6 current United States Centers for Disease Control and Prevention standards; -medication and treatment management; -delegation of tasks by registered nurses or licensed health professionals; As a result of this survey, the following orders were issued 0620, 0630, 0650, 1370, 1380, 1470, 1530, 1620, 1710, 1730, 1750, 1760, 1770, 1790, 1910, 1940, 1950, 2310, 3000, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the	0 470		

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0 470	Continued From page 7 requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure that one or more persons were available to respond to the requests of residents for assistance with health or safety needs when there was no staff present in the building for approximately 2.5 hours, leaving all eight residents alone in the building. This resulted in an immediate correction order on June 14, 2022, at 9:39 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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 June 13, 2022, at 8:45 a.m. upon entrance to the assisted living facility, registered nurse (RN)-B stated she was covering the floor (providing services). RN-B stated, "I have four	0 470		

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0 470	Continued From page 8 people [residents] left to pass medications to." During entrance conference on June 13, 2022, at 10:44 a.m. RN-B stated staffing consisted of unlicensed personnel (ULP): one person was scheduled for the shifts of 6:00 a.m. to 2:00 p.m., 2:00 p.m. to 10:00 p.m. and 10:00 p.m. to 6:00 a.m. On June 14, 2022, at 6:33 a.m. ULP-D was observed to administer medications to R1. On June 14, 2022, at 6:44 a.m., R1 was asked if there was ever a time when staff did not keep a scheduled appointment. R1 stated, "Yesterday, one worker left and there was no one here. I guess someone got sick." When the surveyor asked what time R1 had received her morning medication scheduled for 6:30 a.m. R1 stated, "I got pills at 12 noon. She didn't come until then. I was alright." On July 14, 2022, at 8:19 a.m., RN-B stated when surveyor inquired if there was no staff present in the building yesterday morning, RN-B stated "For the overnight shift [the resident] call pendent rings to the phone carried by the "CNA" [certified nursing assistant] at the nursing home to answer. We had a scheduling issue. The person carrying the phone, CNA from care center did not call me. I got a call before 8:00 a.m. no one was in the building. I got here by 8:15 a.m. There was an unintended gap in the building." RN-B stated for "nights" there were "five standing rotation in two week period" in which the CNAs from the care center covered. RN-B stated the "CNA had the phone Sunday night." RN-B stated the CNAs were to make "two rounds in the eight hour shift, walk all floors and if anyone [residents] activates the pendants, answer it like call light at nursing	0 470		

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	20583	A. BUILDING: _____ B. WING _____	06/16/2022

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0 470	Continued From page 9	0 470		

home." RN-B stated "for anything requiring more than 10 minutes, I can come over and expect to know about that." RN-B stated the ULP "scheduled [for Sunday night] tested positive for COVID last week and did not call the scheduler." RN-B stated she had called ULP-E Sunday and stated "looks like you are not feeling well, looks like you are out for tomorrow." RN-B stated "she didn't tell me she was on the schedule or let the scheduler know." RN-B stated the "CNA shift ended at 6:00 a.m." RN-B stated when the ULP arrive for the morning shift, the ULP will "go and get the phone from the care center and ask the CNA about the night, any lights." When asked if the CNA handed off the phone to the ULP of the licensee, RN-B stated "That did not happen." RN-B stated, "Instructions are to call me if anything happens, I would have liked to be called." RN-B stated the "HUC [health unit coordinator] from the nursing home called me." RN-B called the HUC at the nursing home and asked what time she had called her yesterday morning to alert there was no staff in the assisted living facility (ALF) and was informed over the phone "8:22 a.m." RN-B asked the HUC "how did you know no one was here?" and the HUC stated, "[R3 from the ALF] called me."

The licensee lacked coverage of staff from 6:00 a.m. until 8:22 a.m. when the RN was notified and came to the facility.

The licensee's schedule for the month of June 2022, indicated for the night shift on June 12 starting at 10:00 p.m. "NH" (nursing home) was scheduled to cover the night shift and ULP-E was to start shift at 6:00 a.m. on June 13, 2022.

The licensee Daily Staffing Report dated June 12, 2022, had no documented evidence the nursing

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0 470	Continued From page 10 home staff was scheduled for the night shift. The report indicated "RA [resident assistant] 10:00 p.m. to 6:30 a.m." for a total of eight (8) hours. On June 14, 2022, at 12:25 p.m. RN-C verified the Daily Staffing Report dated June 12, 2022, had no documented evidence of NH staff covering for the night shift. VARIANCE On June 14, 2022, at 12:30 p.m. RN-C was informed the licensee needed a variance to utilize the nursing home staff. RN-C was not aware a variance was needed to utilize the nursing home staff at the assisted living facility. The licensee Staffing policy dated August 1, 2021, indicated the "Clinical Nurse Supervisor (CNS) will develop and implement a written staffing plan that provides an adequate number of qualified, awake direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. When developing the staffing plan, the CNS will ensure that staffing levels are adequate to address the following: a. Each resident's needs, as identified in the resident's service plan and assisted living contract; b. Each resident's acuity level as determined by the most recent assessment or individualized review; c. The ability of staff to timely meet the resident's scheduled and reasonable foreseeable unscheduled needs given the physical layout of the care center premises". No other information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On June 15, 2022, at 11:34 a.m. immediacy was	0 470		

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0 470	Continued From page 11 removed as confirmed by email correspondence with evaluation supervisor, but non-compliance remains. TIME PERIOD FOR CORRECTION: Two (2) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 480		

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0 480	Continued From page 12 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 14, 2022, for the specific Minnesota Food Code deficiencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information related to the grievance procedure, resident advocacy information, and information for reporting suspected maltreatment. This had the	0 550		

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0 550	Continued From page 13 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 June 13, 2022, at 10:09 a.m. observation of posted information in a red folder located on the wall in the main lobby area included Right to File a Grievance dated January 9, 2017, and Reporting Grievance policy dated January 9, 2017. The Right to File a Grievance and Reporting Grievance policy posted in the main lobby failed to include: -contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities On June 15, 2022, at 11:26 a.m. registered nurse (RN)-C stated the licensee's Right to File a Grievance and Reporting Grievance policy, located in the red folder was the licensee's posting for the facilities grievance procedure. RN-C stated, "We utilize it all for posting." RN-C confirmed the posted information lacked the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 550		

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0 550	Continued From page 14 (21) days	0 550		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R5) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's Progress Notes indicated the following: -January 24, 2022, at 10:33 a.m. R5 was noted by off duty staff yesterday, walking out of the Covered Bridge Park. The temp was in single	0 620		

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0 620	Continued From page 15 digits with wind chill below zero. She told staff yesterday that she was searching in the building for a little girl she thought had left a stuffed animal which she was carrying. She is frequently up wandering in the halls around 4:00 a.m. -January 27, 2022, at 3:00 p.m. Writer informed family members that at this point resident's decline in cognition is jeopardizing her safety and wellbeing with recent elopements outside of building in below zero temperatures. Informed family members that a report was made to MAARC due to resident being a vulnerable adult. The licensee provided an email dated January 27, 2022, at 4:03 p.m. sent by registered nurse (RN)-B to RN-C, licensed assisted living director (LALD)-A and two other employees of the licensee "This is the VA [vulnerable adult] report I filed for self-neglect" and indicated the resident left the assisted living about 9 a.m. on the morning of January 25, 2022, to go for a walk. The temp outside was -26, according to a thermometer two blocks north of the building. Staff went to her room to give her meds and she was not there. She was gone for 45 minutes to 1 hour, which is much longer than normal. It is unknown where she was as due to her advanced dementia she can not explain that. She did not sustain any discernable injury. On June 15, 2022, at 9:41 a.m. RN-B stated unlicensed personnel (ULP)-D on January 24, 2022, noticed R5 at the Covered Bridge Park. On June 15, 2022, at 9:41 a.m. RN-C stated, "Yes it is" in regards to the incident being reported three days after the license became aware for the situation. RN-C stated, "The vice president [of the licensee] called me to intervene and I gave direction to report on the 27th."	0 620		

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0 620	Continued From page 16 The licensee's Maltreatment Prohibition policy dated August 1, 2021, indicated for guidelines for reporting abuse, if neglect or abuse is suspected a report must be filed immediately (within 24 hours). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an 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 develop and implement an individual abuse prevention plan that included an 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 for one of one resident (R1) with record reviewed.	0 630		

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0 630	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 14, 2022, at 6:33 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1. R1's Assessment for Client Vulnerability, Safety and Risk to Others dated April 22, 2022, identified "check the appropriate statement(s): client does not appear to pose a threat to other vulnerable adults; client may pose a risk to other vulnerable adults as identified above"; however, there was no "check" indicating which statement was applicable, as directed on the assessment. In addition, the assessment failed to address the person's susceptibility to abuse by another individual, including other vulnerable adults as required. On June 16, 2022, at 11:47 a.m. registered nurse (RN)-C stated regarding R1's assessment "it does not address" R1's risk of abusing other vulnerable adults and "it's not there" regarding the assessment addressing the person's susceptibility to abuse by another individual, including other vulnerable adults. The licensee's Maltreatment Prohibition policy	0 630		

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0 630	Continued From page 18 dated August 1, 2021, indicated an assessment would be completed by a RN for the residents receiving health and personal cares services. The vulnerability assessment was a component of the health services evaluation and based on the assessment the RN would create an individualized abuse prevention plan for each resident receiving health related care and service. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at	0 650		

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0 650	Continued From page 19 least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an annual performance review was completed for one of one unlicensed personnel (ULP-D) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D had a hire date of August 14, 2017, and provided services under the comprehensive home care license, and on August 1, 2021, began providing assisted living services. On June 14, 2022, at 6:33 a.m. ULP-D was observed to administer oral medications to R1. ULP-D's record included a Performance Evaluation Form dated August 19, 2020. ULP-D's record lacked evidence of an annual performance review being completed after August	0 650		

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0 650	Continued From page 20 19, 2020. On June 16, 2022, at 11:47 a.m. registered nurse (RN)-C stated ULP-D "doesn't have one for last year," regarding an annual performance review being completed for ULP-D. The license's Supervision of Licensed and Unlicensed Personnel policy dated August 1, 2021, indicated for annual performance reviews the Licensed Assisted Living Director is responsible for the completion of performance reviews of each staff person, based on the input and documentation of the supervisor's observations and other relevant information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of	0 660		

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0 660	Continued From page 21 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 TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. 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 TB facility risk assessment dated October 13, 2021, indicated the licensee was a low risk. The licensee lacked a written TB infection control plan for the procedures to address early recognition and isolation for handling residents with suspected or confirmed active TB; therefore, none of the licensee's employees had received training on their role in the procedure. The licensee's TB Prevention and Control policy dated June 2019, indicated "Patients with Active TB will not be admitted to the Assisted Living setting or to Home Care. If a client or tenant develops active/infectious TB, the individual will	0 660		

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BRIDGES OF ZUMBROTA	295 WEST 4TH STREET ZUMBROTA, MN 55992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 22 be transferred to a nearby Hospital equipped to treat the disease." The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: written TB infection control procedures. Procedures should address: Early recognition: All health care workers should know the signs and symptoms of TB and their role in their facility ' s TB infection control program. Isolation: Place a potentially infectious TB patient in an airborne infection isolation (AII) room if available; If not, place patient in separate room with door shut. Referral: If your setting does not handle TB patients, transfer potentially infections TB patients to a setting that is equipped to evaluate and treat TB patients. TB training is required at time of hire for all health care workers and the content should focus on basic information: Your health care setting ' s infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing. On June 16, 2022, at 11:43 a.m. registered nurse (RN)-C reviewed the licensee's TB Prevention and Control policy dated June 2019, and confirmed the licensee policy did not address early recognition and isolation for handling residents with suspected or confirmed active TB. RN-C confirmed none of the licensee's employees would have received training on their role in the procedure. No further information was provided. TIME PERIOD FOR CORRECTION:	0 660		

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0 660	Continued From page 23 Twenty-One (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain smoke alarms in the facility and ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors.	0 780		

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0 780	Continued From page 24 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 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 residents). The findings include: On 06/13/2022 between 11:30 AM to 2:00 PM, survey staff observed that the facility had two apartment styles: studio style apartment with no separation from common area and sleeping area, and 1 bedroom apartment with bedroom separate from common area. In both apartment styles there was a smoke alarm in the common area, but the 1 bedroom apartments did not have an additional smoke alarm located in the bedroom area. (RN)-B verbally confirmed survey staff observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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	0 810		

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0 810	Continued From page 25 rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has 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	0 810		

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0 810	Continued From page 26 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 residents). Findings include: On 06/13/2022 between 11:30 AM to 2:00 AM, survey review of documentation showed the following: 1. No records were provided to confirm that 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 exist 2. No records were provided to confirm that the staff of the facility had received initial fire safety and evacuation training at the time of hire, as well as ongoing required twice per year thereafter. 3. No records were provided to confirm that residents capable of assisting in their own evacuation are being trained on proper actions at least annually. 4. No records were provided to confirm that evacuation drills are being conducted twice per year per shift with at least one drill every other month (RN)-B verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 930	Continued From page 27	0 930		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 930		

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0 930	Continued From page 28 the residents). The findings include: R1's Assisted Living Contract was dated July 12, 2021. R1's contract indicated on page fourteen (14), "1. Complaint Procedure/Nondiscrimination [the licensee] recognizes that questions or complaints may arise. It is our goal to address every complaint and concern regardless of source or nature. Questions, concerns and complaints should be addressed first with the appropriate staff person in charge of the area about which resident has a question, concern or complaint. If the matter remains unresolved, resident or resident responsible person should contact the LALD [licensed assisted living director]." In addition, the contract indicated on page nine (9), "11. Resident Handbook, by signing this contract, you agree to abide by the handbook and comply with all of the provider's resident policies, rules, regulations." R1's record identified written acknowledgement for "Resident Handbook Receipt" dated July 12, 2021. The licensee's Resident Handbook indicated "17. Grievance Policy: The grievance policy provides the procedure residents must follow to file a complaint regarding their apartment, common spaces, staff or other residents. To file complaints: a) Contact the LALD and explain the problem requesting resolution." The contract had a LALD listed with address on page one (1) of the contract; however, the name of the LALD was not current and the contract lacked the name of LALD-A and their contact	0 930		

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0 930	Continued From page 29 information. R1's contract lacked the following required content: -the name and contact information of the person representing the facility who is designated to handle and resolve complaints. On June 16, 2022, at 11:46 a.m. RN-C confirmed R1's contract lacked the name and contact information of the person representing the facility who is designated to handle and resolve complaints. RN-C stated, "I think we need to change it then to authorized agent." RN-C verified the licensee's contract would lack the same content for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If	0 940		

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0 940	Continued From page 30 so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 940		

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0 940	Continued From page 31 R1's Assisted Living Contract was dated July 12, 2021. R1's contract lacked the following required content: - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent On June 16, 2022, at 11:46 a.m. RN-C stated, "Yes, we do accept waivers" RN-C stated, "We don't require it," in regards to paying privately for a period of time. RN-C stated, "We don't have that on there," in regards to addressing medical assistance waivers. RN-C verified the licensee's contract would lack the same content for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for injury of a resident. This had the potential to affect all 14 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 potential to affect a large portion or all of the residents). The findings include: R1's Assisted Living Contract was dated July 12, 2021. R1's contract indicated on page nine (9), "11. Resident Handbook, by signing this contract, you agree to abide by the handbook and comply with all of the provider's resident policies, rules, regulations." R1's record identified written acknowledgement for "Resident Handbook Receipt" dated July 12, 2021. The licensee's Resident Handbook indicated "25. Liability: as a corporation, BOZ [the licensee], and it's management cannot be responsible for any injury or damages, which you may suffer as a result of acts of any other resident of BOZ. By signing the contract and lease agreement with the corporation, you acknowledge this position and	0 970		

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0 970	Continued From page 33 waive any claim against BOZ should you suffer any injury resulting from the willful or negligent act of any person other than an employee of the corporation acting within the scope of his/her employment." On June 16, 2022, at 11:46 a.m. RN-C stated, "Yep, I see it" in regards to the licensee's handbook liability statement (as above) referenced as part of the contract. RN-C verified the licensee's contract would include the same content for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01370 SS=D	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;	01370		

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01370	Continued From page 34 (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: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations for the required topics for one of one unlicensed personnel (ULP-D) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01370		

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01370	Continued From page 35 The findings include: ULP-D had a hire date of August 14, 2017. On June 14, 2022, at 6:33 a.m. ULP-D was observed to administer oral medications to R1. ULP-D's record identified Home Care Service Options Home Health Aide Competency Evaluation Form dated August 21, 2017, indicating "method of evaluation 1) verbal 2) written 3) observation." ULP-D record lacked evidence of training (written or oral) for the following: -bathing; -care of teeth, gums, and oral prosthetic devices; and -medication, exercise, and treatment reminders; ULP-D record lacked evidence of competency evaluation for the following: -bathing; -care of teeth, gums, and oral prosthetic devices; -toileting; -standby assistance techniques and how to perform them; On June 16, 2022, at 11:47 a.m. registered nurse (RN)-C verified there was no record ULP-D received the training listed above. RN-C stated "I can't find anything else." The license's Competencies policy dated August 1, 2021, indicated the licensee would competency train and test all staff to assure services to individuals receiving services are performed safely. The training and competency included the above topics.	01370		

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01370	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=D	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 evaluations for the required topics for one of one unlicensed personnel (ULP-D) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	01380		

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	20583	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES OF ZUMBROTA	295 WEST 4TH STREET ZUMBROTA, MN 55992

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01380	Continued From page 37 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D had a hire date of August 14, 2017. On June 14, 2022, at 6:33 a.m. ULP-D was observed to administer oral medications to R1. ULP-D's record identified Home Care Service Options Home Health Aide Competency Evaluation Form dated August 21, 2017, indicating "method of evaluation 1) verbal 2) written 3) observation." ULP-D record lacked evidence of training (written or oral) for the following: -reading and recording temperature, pulse, and respirations of the resident; ULP-D record lacked evidence of competency evaluation for the following: -safe transfer techniques and ambulation; and -range of motioning and positioning; On June 16, 2022, at 11:47 a.m. registered nurse (RN)-C verified there was no record ULP-D received the training listed above. RN-C stated "I can't find anything else." The license's Competencies policy dated August 1, 2021, indicated the licensee would competency train and test all staff to assure services to individuals receiving services are performed safely. The training and competency included the above topics.	01380		

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01380	Continued From page 38 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living	01470		

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01470	Continued From page 39 services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of one unlicensed personnel (ULP-D) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	01470		

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01470	Continued From page 40 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D had a hire date of August 14, 2017. On June 14, 2022, at 6:33 a.m. ULP-D was observed to administer oral medications to R1. ULP-D's record lacked documented evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person On June 16, 2022, at 11:47 a.m. registered nurse (RN)-C confirmed ULP-D's record lacked documented evidence of orientation for introduction and review of the facility's policies and procedures. RN-C further stated "I can't find anything else." The licensee's Orientation and Annual Training policy dated August 1, 2021, indicated all Care Center employees must complete their orientation to assisted living requirements before independently providing services to residents. Orientation to assisted living services needed to be completed only once "but must be provided by our facility." The orientation was not transferable, so employees who have previously worked for another assisted living facility "must complete" this orientation again at our facility and the orientation included an introduction and review of all of our facility's policies and procedures related	01470		

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01470	Continued From page 41 to the provision of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	01530		

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01530	Continued From page 42 Based on interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-D) received the required amount of dementia care training with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D had a hire date of August 14, 2017, and provided direct care services under the licensee's comprehensive home care license until the licensee's conversion to the assisted living license on August 1, 2021. On June 14, 2022, at 6:33 a.m. ULP-D was observed to administer oral medications to R1. ULP-D's record identified the most recent training for dementia topics completed were dated March 26, 28, 29, 2020. ULP-D record lacked at least two hours of training on topics related to dementia for each 12 months of employment as required. In addition, ULP-D's record lacked documented evidence of dementia care training for the topic of person-centered planning and service delivery. On June 15, 2022, at 10:53 a.m. registered nurse (RN)-C stated ULP-D had "none for 2021,"	01530		

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01530	Continued From page 43 regarding the required dementia training for each 12 months of employment. RN-C verified ULP-D lacked the above training for dementia care. The license's Orientation and Annual Training dated August 1, 2021, indicated all employees would complete their orientation to assisted living requirements before independently providing services to residents. If any volunteers provide services to residents, they will also receive orientation to assisted living. In addition to the MN assisted living facility (ALF) regulatory requirements, all staff will be trained in dementia training required by MN Statute Assisted Living 144G.64. The licensee's Alzheimer's Disease or Related Disorder Training policy dated August 1, 2021, indicated training on Alzheimer's disease or related disorders will be provided to all employees upon hire and annually. Direct care employees working in a facility licensed as an Assisted Living would complete this training within 160 working hours of the employment start date and would complete at least 2 hours of training on topics related to dementia for each 12 months of employment thereafter. The areas of training would include an explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, communications skills, understanding cognitive impairment, and behavioral and psychological symptoms of dementia and 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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01530	Continued From page 44 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=D	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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted comprehensive monitoring and reassessment as needed with a change in condition and not to exceed 90 calendar days from the last date of the	01620		

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01620	Continued From page 45 assessment and had conducted assessment for self-administration of medications for one of one resident (R1) with record reviewed. In addition, the licensee failed to ensure the RN had completed and/or documented a comprehensive assessment for change in condition for one of one resident (R6) related to falls. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's diagnoses included congestive heart failure (CHF) and diabetes. R1's Service Plan dated July 29, 2021, identified R1 received medication administration/management, blood sugar monitoring, daily weight and international normalized ratio (INR) test (blood test for clotting.) On June 14, 2022, at 6:33 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1. R1's Progress Notes indicated the following: -dated October 22, 2021, documented by RN-B: returned to her apartment, discharged from (skilled nursing facility), where she was receiving occupational therapy (OT) and physical therapy	01620		

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01620	Continued From page 46 (PT) rehab services from "10/8/21 to 10/22/21." She is independent with activities of daily living (ADLs) and mobility. She is going to use a two wheeled walker in the bathroom. Medication change: Lisinopril (used to treat high blood pressure) increased from 10 milligrams (mg) to 20 mg daily. She is alert and oriented. R1's record identified assessments by the RN were completed as follows: -October 25, 2021 (3 days after readmission); and -January 25, 2022 (92 days from last assessment) R1 lacked a comprehensive assessment upon return to the facility and within 90 days from the last assessment as required. R1's eMAR (electronic Medication Administration Record) Summary dated June 2022, indicated "Additional notes: may leave medications with resident to take later" under a medication being given for diabetes and "does self" for application of a medication to the skin for rash. R1's record lacked an assessment by the RN for self-administration of medications for the above. On June 16, 2022, at 11:46 a.m. RN-C stated the reason a comprehensive assessment was not completed for R1 on day of return to the facility was due to RN-B "wasn't here every day." RN-C stated the reason R1's assessment was not completed as required (not to exceed 90 calendar days from the last date of the assessment) was a "software glitch, now fixed." RN-C reviewed R1's record and stated, "Nope not on assessment" regarding assessment for self-administration of medications.	01620		

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01620	Continued From page 47 R6 R6's record lacked evidence the RN had conducted an assessment of the resident for a change in condition related to falls, including an assessment for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury. R6 diagnoses included systolic (congestive) heart failure, atrial fibrillation and polyosteoarthritis. R6's Service Plan dated August 1, 2021, indicated R6 received bed linen changes weekly, housekeeping weekly, laundry, trash removal, daily check, pendent check, bathing/shower assist weekly, Tubi-grips (compression) apply and removal daily, daily weight, oxygen assist, medication administration and med planner set up at least every two weeks. R6's Assessment for Client Vulnerability, Safety and Risk to Others dated April 25, 2022, indicated R6 had a history of falls, was vulnerable to ambulate safely with-without assistive devices; safe use of assistive devices and intervention of staff, remind her to use a walker and maintain apartment. R6's record included the following Incident Forms and Progress Notes: -March 12, 2022, at 5:30 p.m. Incident Form indicated fall in living room. Resident leaned forward on her recliner and slid onto the footrest and then the floor. No injuries. Action taken at 5:45 p.m. on March 12, 2022: staff person measured vital signs (VS), called 911 for assist off the floor and remained with resident. "Root Cause Analysis of fall: analyze data regarding fall and describe any additional data collected" and	01620		

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01620	Continued From page 48 "Service Plan updated with new Action (intervention) - describe:" lacked documentation. -March 29, 2022, at 11:30 p.m. Incident Form indicated fall in kitchen area. Resident stated she was cleaning grapes at the kitchen sink, turned and slipped to the floor. "Root Cause Analysis of fall: analyze data regarding fall and describe any additional data collected;" had her walker with her in the kitchen, brakes were not locked. No clutter or water on the floor. She called for assistance with her pendant. Was up at an unusual hour to be washing fruit. Possibly experiencing confusion re time of day. "Service Plan updated with new Action (intervention) - describe:" lacked documentation. Hospice visited on March 30, 2022, found no ill effects of the fall. No injuries or concerns. Action taken at 11:40 p.m. on March 29, 2022: staff assessed for injury, no pain noted with movement of limbs. Check vital signs. Called 911 for assist up fro the floor. Rechecked blood pressure after 20 minutes. -March 29, 2022, Progress note indicated resident used her pendant to call for help on March 29, 2022 about 11:30 p.m. She was found lying on the floor. She had her walker with her in the kitchen. She said she was washing grapes and turned around and slid to the ground. The brakes were not locked on the walker. No clutter or water on the floor. Staff assessed for injury or pain, checked VS, called 911 for lift assistance. Staff called nurse on call. Was up at an unusual hour to be washing fruit. Possibly experiencing confusion re time of day. She takes zolpidem (Ambien) for sleep which may cause confusion. -April 16, 2022, at 9:15 p.m. Incident Form indicated fall in bathroom. Resident stated she needed to use the toilet so she got up. Sometimes confused after taking Ambien (sedative) for sleep. "Root Cause Analysis of fall: analyze data regarding fall and describe any	01620		

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01620	Continued From page 49 additional data collected"; Unsteady gait, had taken bedtime Ambien. "Service Plan updated with new Action (intervention) - describe:" lacked documentation. No injuries. Action taken certified nursing assistant (CNA) called the director of nursing (DON) who came from home. Checked vital signs. Checked for injury and pain with range of motion. Called 911 for transfer assistance. Assisted form floor with three assist with walker and gait belt. Assisted to the toilet and back to bed. -April 16, 2022, Progress Note indicated resident used her pendant to call for assistance about 9:20 p.m. She was found on the floor of the bathroom. CNA [certified nursing assistant] called DON to report and then called 911 for lift assistance. Resident denied pain, had no injuries. Was alert, said she was up to go to the toilet. Assist of three with gait belt, used the toilet and went back to bed. Vitals blood pressure 168/90, pulse 86, respirations 20, temperature 97.8, oxygen level 95% (percent). Called hospice to report. -April 18, 2022, Progress Note indicated new hospice orders: DC (discontinue) Zolpidem; start Trazodone (antidepressant) 50 milligrams (mg) take 1/2 tablet (25 mg) by mouth at bedtime for insomnia. Although Incident Forms were completed for the above falls, R6's record lacked evidence of a documented comprehensive assessment by the RN for a change in condition related to the falls as above, lacked evidence of documented review for potential causative factors for some of the falls above to determine specific interventions or lacked implementation of interventions to minimize the risk for future falls and potential injury.	01620		

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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
01620	Continued From page 50 On June 15, 2022, at 2:33 p.m. RN-B stated "Nope it's not there," regarding documented interventions implemented for the above falls. RN-B stated interventions for falls implemented "show up on the service plan" and there was "none there," referring to no interventions were documented on R6's service plan. RN-B stated R6 did not have dementia and could be reeducated. RN-B stated, "No" regarding completing a comprehensive nursing assessment for R6 related to the falls. RN-B stated, "If no documentation" of root cause and interventions implemented then "not in record." RN-C stated, "I don't see it on there" regarding documentation for root cause, intervention, RN assessment for fall on March 12, 0222. RN-C stated for the fall on March 29, 2022, the "hospice nurse evaluated" R6. RN-C stated, "Nope" regarding documentation for root cause, intervention, RN assessment for fall on April 16, 2022. The licensee's Nursing Assessment policy dated April 8, 2022, indicated a RN would complete a comprehensive nursing assessment of the resident's physical, mental and cognitive needs as required for on-going assessment completed periodically, but no less than every 90 days and change in resident condition and as indicated by individual resident circumstances. At these re-assessments, the RN would review the resident's service plan, evaluate the resident's medication management services and the resident's medications, evaluate the resident's treatments, if any, communicate any new problems or concerns to the resident's physician or health care providers, and update the service plan as necessary based on the resident's needs. No further information was provided.	01620		

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	20583	A. BUILDING: _____ B. WING _____	06/16/2022

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01620	Continued From page 51 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	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. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan was revised, based on resident reassessment for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a	01640		

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01640	Continued From page 52 violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Service Plan dated July 29, 2021, included medication administration/management, blood sugar results recorded one time per day, daily weight, housekeeping, daily check, pendant check, trash removal, bed linen change, laundry, meals and international normalized ratio (INR) test (blood test to determine clotting factor.) On June 13, 2022, at 10:44 a.m. registered nurse (RN)-B stated she "set up [R1's] Warfarin [coumadin/blood thinner] in a cassette." RN-B stated medications were "set up weekly" in cassettes. On June 14, 2022, at 6:33 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1 from pre-packaged pharmacy envelopes. A blue medication cassette for one week was observed labeled with "coumadin" (blood thinner) for one week of medication set up. ULP-D stated R1 "writes down her blood sugar and we [staff] put it [record] in tablet [electronic health record]. Blood sugar results were observed documented twice daily on a calendar hanging on a wall in R1's apartment. R1's Monthly Task Log dated June 2022, included the service of "nurse will complete fingernail care for the resident. Notify the nurse when resident	01640		

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01640	Continued From page 53 needs nail care," "Warfarin 3 mg [milligrams] tabs [tablets] in a bottle. Read directions in med order carefully, dosing has the potential to change at any time" and identified "BS [blood sugar] result recorded" were being documented for a.m. and p.m. times by staff. R1's Service Plan lacked revision to include the service of medication set up in cassette and fingernail care as needed by the RN and blood sugar results being documented (monitored) twice daily. On June 16, 2022, at 11:46 a.m. RN-C stated R1's service plan "should have been revised" to include the services of medication set up in cassette and fingernail care as needed by the RN. The licensee's Content, Development and Revision of the Service Plan policy dated August 1, 2021, indicated all care center residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and as requested and/or agreed upon by the resident or the resident's representative. Revisions to the service plan would occur whenever changes are needed to the services to be provided. The RN would make necessary changes to the service plan. 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	01650		

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01650	Continued From page 54 (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 observation, interview and record review, the licensee failed to ensure the service plan included all required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01650		

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01650	Continued From page 55 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's Service Plan dated July 29, 2021, included "Assessment and Monitoring: Unless there are unexpected circumstances, an in-person, face to face individualized initial assessment b a registered nurse will be conducted prior to signing a contract with the assisted living facility. A review of the assessment may be completed within 72 hours of the initiation of health related services, if services begin at the time of move in and will be completed within 72 hours of the initiation of health related services when initiated at a later time. Resident reassessment will be conducted in the resident's home no later than 14 days after initiation of services. Ongoing resident monitoring and reassessment will be conducted as needed based on changes in the needs of the resident and will not exceed 90 days from the last date of the assessment." On June 14, 2022, at 6:33 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1. In addition, R1's service plan included the name of a prior employee RN with phone number and indicated for "circumstances in which medical services are not to be provided" an "x" was placed in a box next to "need for CPR" (cardiopulmonary resuscitation) and handwritten was "is a DNR" (do not resuscitate). R1's Service Plan lacked the following content: - the schedule and methods of monitoring	01650		

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01650	Continued From page 56 assessments of the resident (or the date on which a prospective resident moves in, whichever is earlier) - a contingency plan that includes: (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C (health directive (CPR/DNR) and/or living will). On June 16, 2022, at 11:46 a.m. RN-C verified the service plan lacked "or the date on which a prospective resident moves in, whichever is earlier" for assessment by the RN. RN-C stated in reference to an assessment being conducted, "we do sometimes on the date of move in." RN-C stated the the information documented on R1's service plan for "circumstances in which medical services are not to be provided, is very confusing." RN-C verified the service plan did not address a living will. RN-C reviewed the service plan and stated, "Not on there" regarding information and method to contact the facility. RN-C verified the licensee's contract would lack the same content for all residents. The licensee's Content, Development and Revision of the Service Plan policy dated August 1, 2021, indicated a service plan established after completion of full individualized initial assessment and each subsequent reassessment included the schedule and method of monitoring assessments of the resident and a contingency plan that included the circumstances in which emergency medical services are not to be summoned consistent according to resident wishes and as ordered on the POLST (Provider Orders for Life Sustaining Treatment). The policy did not address living will according to chapters 145B. No further information was provided.	01650		

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01650	Continued From page 57 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure reassessment of medication management services at a minimum annually for one of one resident (R1), with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 had an admission date of January 28, 2019, with diagnoses including diabetes and congestive heart failure (CHF). R1's Service Plan dated July 29, 2021, included	01710		

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01710	Continued From page 58 medication administration/management. On June 14, 2022, at 6:33 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1. R1's eMAR (electronic Medication Administration Record) Summary dated June 2022, indicated staff were administering three medications to treat high blood pressure, one medication to treat high cholesterol, three supplement medications, one medication used to reduce fluid retention, two used to treat diabetes, one used to treat watery eye, one used for heart, one used to treat stomach acid, one blood thinner, one used for shortness of breath, one used for constipation, one used for chest pain and two used for yeast/rash areas of the skin. R1's assessment dated April 22, 2022, included "Assessment Section: Medication Review." The review indicated there were no adverse reactions, the resident does not show any drug allergies (including life threatening) or sensitivities or contraindications for use, indicated the RN had completed a medication review of each of the the resident's prescriptions, over-the-counter medications and supplements, as defined in rule and addressed diversion and instructions to resident/resident representative. R1's record lacked a medication reassessment by the RN conducted face-to-face with the resident, with the following required content: - identification of all medications the client was known to be taking, including the medication name, indications for medications and side effects (the review did not identify source/list of medications reviewed).	01710		

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01710	Continued From page 59 On June 16, 2022, at 1:30 p.m. RN-C stated RN-B "did not do medication assessment form we sent out," to be utilized for medication assessments. RN-C confirmed R1's record lacked the above content. The licensee's Individualized Medication, Treatment and Therapy Management policy dated May 17, 2022, indicated the licensee would have a RN would reassess the resident's medication, treatment and therapy management services as needed when the resident presents with symptoms or other issues that may be medication, treatment or therapy-related and, at a minimum, annually. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01710		
01730 SS=D	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;	01730		

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01730	Continued From page 60 (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, 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 ensure an individualized medication management record to include all required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	01730		

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01730	Continued From page 61 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Service Plan dated July 29, 2021, included medication administration/management. On June 13, 2022, at 10:44 a.m. registered nurse (RN)-B stated she "set up [R1's] Warfarin [coumadin/blood thinner] in a cassette." RN-B stated medications were "set up weekly" in cassettes. On June 14, 2022, at 6:33 a.m. unlicensed personnel (ULP)-D was observed to administer oral medications to R1. ULP-D obtained medications from a locked kitchen cupboard in the R1's apartment. A blue medication cassette for one week was observed labeled with "coumadin" (blood thinner) for one week of medication set up. Insulin Pens were observed stored in R1's refrigerator. At 8:38 a.m., ULP-D was observed to administer insulin to R1 via an insulin Pen. R1's eMAR (electronic Medication Administration Record) Summary dated June 2022, indicated staff were administering three medications to treat high blood pressure, one medication to treat high cholesterol, three supplement medications, one medication used to reduce fluid retention, two used to treat diabetes, one used to treat watery eye, one used for heart, one used to treat stomach acid, one blood thinner, one used for shortness of breath, one used for constipation, one used for chest pain and two used for yeast/rash areas of the skin.	01730		

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01730	Continued From page 62 R1's assessment dated April 22, 2022, included an "Assessment section: Individualized Medication Management Plan." The plan indicated medications would be administered by facility staff and "AL" (assisted living) would order meds and supplies from the pharmacy as needed. A "Medication Management" section indicated insulin stored in refrigerator until pen initiated/medications stored in locked cupboard and addressed risk of diversion. R1's individualized medication management record lacked the following: - a statement describing the medication management services that will be provided (medication set up in a cassette by RN); - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - 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. On June 16, 2022, at 11:47 a.m. RN-C stated, "If not there, then not being addressed," regarding R1's individualized medication management record. RN-C stated the ULP "do not have to call the nurse" to administer an as needed (PRN)medication and it would be at "the nurse's	01730		

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01730	Continued From page 63 discretion." RN-C verified there were no documented instructions when to notify the nurse regarding medications being administered to R1 (Warfarin, PRN fluid retention medication for weight gain, PRN medication for rash). The licensee's Individualized Medication, Treatment and Therapy Management policy dated May 17, 2022, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that would contain the content as above. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing,	01750		

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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
01750	Continued From page 64 specific instructions for one of one resident (R1) for administration of medications and one of one unlicensed personnel (ULP-D) was instructed in the proper methods and had demonstrated the ability to competently follow the procedures, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Service Plan dated July 29, 2021, included medication administration/management. On June 14, 2022, at 6:33 a.m. ULP-D was observed to administer oral medications to R1. A blue medication cassette for one week was observed labeled with "coumadin" (blood thinner) for one week of medication set up. At 8:38 a.m., ULP-D was observed to administer insulin to R1 via an insulin Pen. R1's eMAR (electronic Medication Administration Record) Summary dated June 2022, indicated staff were administering three medications to treat high blood pressure, one medication to treat high cholesterol, three supplement medications, one medication used to reduce fluid retention, two used to treat diabetes, one used to treat watery eye, one used for heart, one used to treat stomach acid, one blood thinner, one used for pain, one used for shortness of breath, one used	01750		

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	20583	A. BUILDING: _____ B. WING _____	06/16/2022

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01750	Continued From page 65 for constipation, one used for chest pain and two used for yeast/rash areas of the skin. R1's eMAR dated June 2022, lacked specific instructions to take medication whole and/or with meal or immediately following meals for amlodipine (swollow whole), metoprolol tartrate (with a meal or just after a meal/swollow whole), metformin HCl (swallow whole), atrovastatin calcium (swallow whole) and aspirin delayed release (swallow whole). ULP TRAINING AND DEMONSTRATED COMPETENCY ULP-D had a hire date of August 14, 2017. On June 14, 2022, at 6:33 a.m. ULP-D stated she "administered oral medications and administered insulin after breakfast" to R1. ULP-D stated she was "trained in by another RN [prior RN at facility] and RA [resident assistant]" at the time she was hired for medication administration. ULP-D's Home Care Service Options Home Health Aide Competency Evaluation Form dated August 21, 2017, indicated "method of evaluation 1) verbal 2) written 3) observation." The form identified documented method of "3" for "has a working knowledge of medications a) can do a med assist without errors," method "1" for "knows general categories of medications and can identify general side effects." ULP-D's record lacked documented training (evidence of a verbal or written test) and skills demonstration (evidence of a written procedure and indication of pass or fail for competency evaluations): -medication administration (all routes)	01750		

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01750	Continued From page 66 On June 16, 2022, at 11:47 a.m. RN-C verified R1's record lacked the specific instructions above for medications. RN-C stated regarding ULP-D's record for training and competency for medication administration, "I can't find anything else." RN-C stated there was "no written procedures, only the list" for description of content for the topics ULP-D received training on by method of evaluation of verbal or written or observation. The license's Delegation of Nursing Tasks policy dated August 1, 2021, indicated a RN may delegate medication administration to unlicensed personnel only after the RN had instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures and developed specific written instructions for each resident and documented those instructions in the resident's medication record/MAR. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any	01760		

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01760	Continued From page 67 follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions observed with insulin administration via a prefilled insulin pen; failed to ensure documented site of injection; failed to ensure medications were administered within time specified and documented at time of administration for one of one resident (R1), with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: INSULIN ADMINISTRATION/DOCUMENT INJECTION SITE R1's Physician Order Review dated June 7, 2022, included an order for Lantus (long acting insulin) SoloStar Solution Pen-Injector 26 units one time per day every morning. R1's eMAR (electronic Medication Administration Record) Summary dated June 2022, included insulin Lantus SoloStar Solution Pen-Injector	01760		

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01760	Continued From page 68 inject 26 units every morning at 8:30 a.m. The MAR indicted the medication was administered, but lacked documentation of the site in which the medication had been injected. On June 14, 2022, at 8:38 a.m. unlicensed personnel (ULP)-D was observed to administer insulin to R1 via an insulin Pen. ULP-D dialed up to 26 units on the insulin pen and injected the insulin into R1's left abdomen. At the time ULP-D stated, "That's all there is [referring to 26 units left in the insulin pen]. Usually I prime it [the pen] with one unit, but that's all there is." ULP-D stated, "No" regarding documenting the site where the injection was given. The manufacturer instructions for the Lantus insulin pen provided by the licensee, indicated "Step 3. perform a safety test; dial a test dose of 2 units. press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. Step 4. Select the dose; make sure the window shows zero and then select the dose. if you don't have enough insulin for the rest of your dose, you will need to use a new pen." The website Insulin Routines - American Diabetes Association, copyright 2022, indicated Insulin Routines; insulin should be injected into the same general area of the body for consistency, but not the exact same place. Insulin delivery should be timed with meals to effectively process the glucose entering your system. Site Rotation; the place on your body where you inject insulin affects your blood sugar level. Insulin enters the blood at different speeds when injected at different sites. Insulin shots work fastest when	01760		

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01760	Continued From page 69	01760		

given in the abdomen. Insulin arrives in the blood a little more slowly from the upper arms and even more slowly form the thighs and buttocks. Injecting insulin in the same general area (for example your abdomen) will give you the best results from your insulin. Don't inject the insulin in exactly the same place each time, but move around the same area. Each mealtime injection of insulin should be given in the same general area for best results. For example, giving your before breakfast injection in the abdomen each day and your before supper insulin injection in the leg each day give more similar blood sugar results. If you inject near the same place each time, hard lumps or extra fatty deposits may develop. Both of these problems make the insulin reaction less reliable. Timing; insulin shots are most effective when you take them so that insulin goes to work when glucose from your food starts to enter your blood. For example, regular insulin works best if you take it 30 minutes before you eat.

On June 14, 2022, at 9:01 a.m. registered nurse (RN)-B stated the insulin pen should be primed with "one or two units" before the dose to be administered was dialed up. RN-C stated, "It's two," referring to units to be dialed to prime the pen.

MEDICATION ADMINISTRATION/DOCUMENTED
R1 was administered a.m. medications late and the RN failed to document the administration time of the medications once the medications were given.

On June 13, 2022, at 8:45 a.m. upon entrance to the assisted living facility, RN-B stated she was covering the floor (providing services). RN-B stated, "I have four people [residents] left to pass

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01760	Continued From page 70 medications to." On June 14, 2022, at 6:44 a.m. R1 was asked if there was ever a time when staff did not keep a scheduled appointment. R1 stated, "Yesterday, one worker left and there was no one here. I guess someone got sick." When the surveyor asked what time R1 had received her morning medication scheduled for 6:30 a.m. R1 stated, "I got pills at 12 noon. She didn't come until then. I was alright." R1's eMAR Summary dated June 2022, identified R1 was to receive nine medications orally for the time of 6:30 a.m. and an insulin injection at 8:30 a.m. on June 13, 2022. The eMAR lacked a staff person's signature for medication administration. On June 14, 2022, at 11:2 a.m. RN-B stated she was "not aquatinted with the Ipad [electronic tablet] to document medications given" in R1's eMAR. RN-B stated R1 "was the second one I went to. I'd say 9:15 a.m.," referring to the time she gave R1 her a.m. medications on June 13, 2022. RN-B verified the actual time she administered the medications was not documented. The licensee's Administration of Medications, Treatment and Therapy by Unlicensed Personnel policy dated February 15, 2022, indicated the RN may delegate to Resident Assistant (RA) administration of medications if the RA had satisfied the training requirements and before performing the procedures, the RN had instructed the Resident Assistant in the proper methods to administer the medications, the RA had demonstrated the ability to competently follow the procedures and the RN developed written, specific instruction for each resident.	01760		

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01760	Continued From page 71 The license's Documentation of Medications, Treatments, and Therapy Management Services policy undated, indicated staff will document each task immediately after that task has been performed. When electronic health records are utilized, staff will document within the record recording time that the medication was administered and documentation of any given instructions. The policy did not address documentation of site for insulin injections. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication setup as required for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01770		

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01770	Continued From page 72 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee failed to ensure documentation for medication setup in a medication dosage box was completed at the time of setup. On June 13, 2022, at 10:44 a.m. registered nurse (RN)-B stated she "set up [R1's] Warfarin [coumadin/blood thinner] in a cassette." RN-B stated medications were "set up weekly" in cassettes. On June 14, 2022, at 6:33 a.m. unlicensed personnel (ULP)-D was observed to administer oral medications to R1. A blue medication cassette for one week was observed labeled with "coumadin" (blood thinner) for one week of medication set up. R1's record lacked evidence of 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 at the time of setup. On June 15, 2022, at 3:52 p.m. RN-C stated, "Medication set-up was not documented." The licensee's Documentation of Medication, Treatment and Therapy Management Services policy undated, indicated staff will document each task immediately after the tasks has been performed. The policy did not address documentation of pre-set up of medications into a medication dosage box. No further information was provided.	01770		

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01770	Continued From page 73 TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be	01790		

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01790	Continued From page 74 labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. 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 for one of one unlicensed personnel (ULP-D) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01790		

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01790	Continued From page 75 or has the potential to affect a large portion or all of the residents). The findings include: The licensee's policy indicated staff could send medications with a resident for an unplanned leave of absence as directed by the nurse. ULP-D had a hire date of August 14, 2017. On June 14, 2022, at 6:33 a.m. ULP-D was observed to administer oral medications to R1. ULP-D's Home Care Service Options Home Health Aide Competency Evaluation Form dated August 21, 2017 indicated "method of evaluation 1) verbal 2) written 3) observation." The form identified documented method of "3" for "has a working knowledge of medications a) can do a med assist without errors," method "1" for "knows general categories of medications and can identify general side effects." ULP-D's record lacked evidence to indicate the registered nurse (RN) provided training and determined competency to prepare and administer medications to residents for unplanned times away. On June 16, 2022, at 11:47 a.m. RN-C stated regarding ULP-D's record "I can't find anything else," for training and determined competency to prepare and administer medications to residents for unplanned times away. The license's Medication to be Given When Away From Home policy dated August 1, 2021, indicated if the resident's medications are stored in a locked container accessible only to facility	01790		

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01790	Continued From page 76 staff, the staff person who gives the medications and any accompanying instructions or information to the resident or the resident's representative would document the process as described below, including staff would contact the nurse prior to giving medications to the resident or resident representative if there were any questions about what medications could be sent or how to send medications. The license's Competencies policy dated August 1, 2021, indicated competencies of ULP for delegated medication tasks the RN would train and competency test staff on those routes of medication administration either currently or most likely to be delegated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01910 SS=E	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in	01910		

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01910	Continued From page 77 the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to dispose of and document disposition of medications for three of three discharged residents (R2, R4, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's record lacked documentation of disposition upon the resident's discharge from the facility. R2's Discharge Summary identified date services were initiated was August 1, 2021, and service end date was April 20, 2022. The summary indicated R2 "received medication management services." R2's "eMar" (electronic medication administration record) dated April 2022, indicated R2 received	01910		

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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
01910	Continued From page 78 the following medications: four for high blood pressure, six supplements, one for cardiac health, two for constipation, one used to reduce fluid retention, one used for pain and one used to treat acid reflux. R2's record lacked documented evidence for the disposition of all of the above medications upon discharge from the licensee's assisted living facility, including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. R4 R4's medications were not disposed of, including documentation of disposition upon the resident's discharge from the facility. R4's Service Plan dated September 23, 2021, included medication administration. R4's Progress notes identified on December 22, 2021, R4 was transferred to an emergency room by ambulance due to not doing well. A note dated January 20, 2022, indicated R4 had been admitted to a skilled nursing facility on December 27, 2021. On June 15, 2022, at 8:38 a.m. observation with unlicensed personnel (ULP)-D identified R4's medications remained in the licensee's medication cart. The medications observed and identified by ULP-D to be R4's medications were: aspirin (used as preventive for cardiac health), allopurinol (used to treat high blood pressure), thiamine (vitamin), lidocaine patches (used for pain), cefdinir (used to treat bacterial infection), Tamsulosin (used to treat enlarged prostate),	01910		

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	20583	A. BUILDING: _____ B. WING _____	06/16/2022

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01910	Continued From page 79	01910		

mirtazapine (used to treat depression), Tylenol (used for pain), calcium carbonate (supplement), Miralax (used to treat constipation), vitamin B-1 (supplement), Tums (used for indigestion), milk of magnesia (laxative), artificial tears (used to treat dry eyes), Bisacodyl suppositories (laxative), enema (laxative) and stool softener medication. At that time, ULP-D stated R4 was no longer a resident of the facility. ULP-D stated, "A few of us [staff] have mentioned to the nurse that [R4's] drugs are in the med cart."

R4's record lacked documented evidence for the disposition of all of the above medications upon discharge from the licensee's assisted living facility, including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.

R5
R5's medications lacked to be disposed of, including documentation of disposition upon the resident's discharge from the facility.

R5's Service Plan Detail last modified January 21, 2022, indicated staff would administer all medications for R5.

R5's Progress notes identified on January 27, 2022, R5's family member decided to take R5 home and the family member chose to take medication cards delivered by the pharmacy. The note further indicated "there were a few back up supplies of medications left on the locked storage cupboard of [R5's] apartment."

On June 15, 2022, at 8:38 a.m. observation with ULP-D identified R5's medications remained in

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01910	Continued From page 80	01910		

the licensee's medication cart. These medications included: calcium with vitamin D3 (supplement), aspirin, tabavite vitamins and one a day women's vitamins.

R5's eMar dated January 2022, indicated R5 received the following medications: one used for osteoporosis, four used to treat high blood pressure, one for cardiac health, one used to treat depression, two supplements and two used for pain.

R5's record lacked documented evidence for the disposition of all of the above medications upon discharge from the licensee's assisted living facility, including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.

On June 15, 2022, at 8:54 a.m. registered nurse (RN)-B stated the licensee's process for destruction of medications was medications were placed in a "pill destroyer" for destruction when a resident was discharged. RN-B stated the "pharmacy does not take medications back, so we have to destroy them or send back to family." RN-B stated, "Evidently, I believe some medications in the medication cart are over due for disposal." RN-B stated, "The medications should have been disposed of within the week" of the resident's discharge.

On June 15, 2022, at 9:36 a.m. RN-C stated regarding destruction of R2's medications upon discharge, "there is a form for that, I gotta find it." RN-B provided a "Record of the Inventory and Destruction of Medications" form with medications listed, including the date, prescription

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01910	Continued From page 81 number, pharmacy, drug name, strength, quantity and two signature areas for persons to sign for destruction. The form did not include a resident name or to whom the medications were given. At the time RN-C stated the form had "no name" of resident and "I had to clarify all her medications yesterday" and "my initials are on the side" of the form for destruction of R2's medications. RN-C confirmed the form failed to include to whom the medications were given or how the medications were disposed of. The licensee's Disposition or Disposal of Medications policy undated, indicated resident's current medications that were secured or stored by the facility would be given to the resident or the resident's representative when the resident's medication management services are terminated. Staff would document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. Disposal of unused or discontinued prescription drugs managed by the agency stored in the resident's private living space may be treated as household waste and may be destroyed by flushing into the sewer system and destroying the labels from the containers. "Documentation of the destruction, listing the date, quantity name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the resident's record for two years." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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01940	Continued From page 82	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individualized treatment or therapy management	01940		

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record to include all required content for one of one resident (R1), with record reviewed.

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

The findings include:

R1's Service Plan dated July 29, 2021, included blood sugar results recorded one time per day and international normalized ratio (INR) test (blood test for clotting ability.)

R1's assessment dated April 22, 2022, included a "Treatment Plan" and indicated R1 had treatment and/or therapy orders.

On June 14, 2022, at 6:33 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1. ULP-D stated R1 "writes down her blood sugar and we [staff] put it [record] in the tablet [electronic health record]. Blood sugar results were observed documented twice daily on a calendar hanging on a wall in R1's apartment.

R1's Monthly Task Log dated June 2022, identified "BS [blood sugar] result recorded" were being documented for a.m. and p.m. times by staff.

R1's eMAR (electronic Medication Administration Record) Summary dated June 2022, included

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01940	Continued From page 84 INR results were sent to anticoagulation clinic one time per day every week on Tuesday by the nurse. Complete INR every week. Goal 2.0-3.0. Notify anticoagulation clinic "ASAP" (as soon as possible) if result is out of range or if resident is acutely ill or other occurrence that may impact INR; otherwise, once monthly, send all INRs to anticoagulation clinic. R1's Physician Order Review dated June 7, 2022, included blood sugar check two times per day, every day at morning and bedtime and INR one time per day every week on Tuesday. Complete INR every week. Goal 2.0-3.0. Notify anticoagulation clinic ASAP if result is out of range or if resident is acutely ill or other occurrence that may impact INR; otherwise, once monthly, send all INR's to anticoagulation clinic. R1's record lacked an individualized treatment and therapy management plan to include: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions.	01940		

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01940	Continued From page 85 On June 16, 2022, at 11:47 a.m. RN-C stated, "They're missing parameters for blood sugar." RN-C verified R1's record lacked an individualized treatment and therapy management plan. The licensee's Individualized Medication, Treatment and Therapy Management policy dated May 17, 2022, indicated for each resident receiving medication, treatment and therapy management services, the licensee would prepare and include in the service plan a written statement of the medication, treatment and therapy management services that would be provided to the resident. The licensee would develop and maintain a current individualized medication management record, but the policy did not address developing and maintaining a current individualized treatment or therapy record. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:	01950		

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01950	Continued From page 86 (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for one of one resident (R1) for monitoring of treatment or therapy and one of one unlicensed personnel (ULP-D) was instructed in the proper methods and had demonstrated the ability to competently follow the procedures, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Service Plan dated July 29, 2021, included blood sugar results recorded one time per day. On June 14, 2022, at 6:33 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1. ULP-D stated R1 "writes	01950		

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01950	Continued From page 87 down her blood sugar and we [staff] put it [record] in the tablet [electronic health record]. Blood sugar results were observed documented twice daily on a calendar hanging on a wall in R1's apartment. R1's Monthly Task Log dated June 2022, identified "BS [blood sugar] result recorded" were being documented for a.m. and p.m. times by staff. R1's Physician Order Review dated June 7, 2022, included blood sugar check two times per day, every day at morning and bedtime. R1's record lacked specified, in writing, specific instructions for the treatment or therapy service for monitoring blood sugars, which included parameters. ULP TRAINING AND DEMONSTRATED COMPETENCY ULP-D had a hire date of August 14, 2017. On June 14, 2022, at 6:33 a.m. ULP-D stated she was "trained in by another RN and RA [resident assistant]," at the time she was hired for blood sugar checks. ULP-D's record identified "verbal" training for "has working knowledge of glucometer" dated August 21, 2017; however, there was no description of what the training content was. ULP-D's record lacked documented evidence of training and demonstrated competency for blood sugar monitoring. On June 16, 2022, at 11:47 a.m. RN-C stated, "They're missing parameters for blood sugar."	01950		

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01950	Continued From page 88 RN-C verified R1's record lacked an individualized treatment and therapy management record. When asked about ULP-D's record for training and competency in blood sugar monitoring, RN-C stated "I can't find anything else." RN-C further stated there was "no written procedures, only the list" for a description on the topics ULP-D received training on by method of evaluation of verbal or written or observation. The license's Delegation of Nursing Tasks policy dated August 1, 2021, indicated a RN may delegate nursing services or assign therapy tasks, to unlicensed personnel that had successfully completed the training required for unlicensed personnel; had been trained in the services to be provided; and had demonstrated to the RN the ability to competently follow the procedures for the resident and possess the knowledge and skills consistent with the complexity of the tasks. A RN may delegate nursing services to unlicensed staff only after including written instructions for performing the procedure for the resident in the resident's record. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01950		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 89 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) who utilized a physical device (bed assist handle), with record reviewed. This resulted in an immediate correction order on June 14, 2022, at 9:39 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on June 13, 2022, at 10:44 a.m. registered nurse (RN)-B stated she had completed an audit and there were no residents who had bedrails, but some residents had assistive devices. RN-B stated she obtained "measurements," completed "informed consents, education was provided to the family and residents" and she had "email" documentation of "suggestions for safety things needed." RN-B stated, "No" to having manufacturer guidelines for any assistive devices being utilized by residents receiving services by the licensee. RN-B stated, "These are some ancient devices. I didn't understand the need to be done," referring to having the manufacture guidelines for assistive devices being utilized by residents.	02310		

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02310	Continued From page 90 R1's Service Plan dated July 29, 2021, noted services included blood sugar result recorded, daily weight, housekeeping, bed linen change, laundry, daily check, pendant check, "INR" test (International Normalized Ratio/blood test), medication management/administration and nurse set up med planner. On June 14, 2022, at 8:38 a.m. R1's bed was observed with unlicensed personnel (ULP)-D to have a bed assist handle on the upper right side of the bed. The bed assist handle was unsecured to the bed and was able to be pulled out from underneath the mattress away from the bed. The side bar of the rail had a sticker with the word "drive," and a middle bar had a white sticker with the words "follow installation instructions to prevent potential patient entrapment" and "patient entrapment may cause injury or death." R1 stated the bed assist handle "helps me to get out of bed. I couldn't do it without that." R1's record included the following: -Informed Consent for Bed/Mobility Rail dated August 22, 2019, which indicated "mobility bar on upper R [right] side of bed to assist with repositioning/transfers. Resident/family recommends bed/mobility rail for getting in or out of bed." The informed consent listed potential benefits from bed/mobility rail and potential risks of bed rail include associated with use of bed/mobility rail. -a sheet dated May 12, 2022, with measurements Zone 1: within the rail 4.5 inches; Zone 2: under the rail/between rail supports or next to single rail support 4.5 inches; Zone 3: between the rail and the mattress 2.75 inches; Zone 6: between the end of the rail and the side edge of the head or foot board 12.5 inches; Zone 7: between the head or foot board and the mattress end 0.5 inches.	02310		

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02310	Continued From page 91 -A Guide to Bed Safety (Revised April 2010) fact sheet signed by R1 on May 12, 2022. R1's assessment dated April 22, 2022, lacked evidence of documented assessment by the RN for use of the bed assist handle on R1's bed. R1's record lacked evidence of manufacturer guidelines for the bed assist handle. On June 14, 2022, at 8:58 a.m. RN-B confirmed the licensee had no manufacturer guidelines for R1's bed assist handle. RN-B stated R1's "family installed" the bed assist handle. RN-B stated she was "not aware" the bed assist handle "pulled out." RN-B stated, "I measured it." The surveyor requested the licensee to obtain the manufacturer guidelines for the bed assist handle. On June 14, 2022, at 9:20 a.m. RN-C provided the manufacturer guidelines "drive" for "bed assist handle." The manufacturer guideline indicated the use of a strap to secure the bed assist handle to the bed. On June 14, 2022, at 9:25 a.m. RN-C stated, "I went in there [R1's apartment]. It's not secure, the whole thing comes out," referring to the bed assist handle attached to R1's bed. RN-B verified there was no strap utilized to secure the bed assist handle to the bed. On June 14, 2022, at 11:33 a.m. RN-C reviewed R1's assessment dated April 22, 2022, and stated "This is why" regarding the assessment lacked documented evidence of assessment for the use of the bed assist handle. The assessment was marked "no" for response to the question of resident uses siderails or other supportive devices.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20583	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES OF ZUMBROTA	295 WEST 4TH STREET ZUMBROTA, MN 55992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 92 The licensee's Assessing the Safety of Bed Rails policy dated August 1, 2021, indicated the assisted living facility clinical nurse supervisor, an RN or RN designee will ensure that a resident with mobility rails on his or her bed has an individual assessment to educate the resident on safe use of the mobility rail. The policy referenced bedrails and Food and Drug Administration (FDA) recommendations. In addition, the policy indicated "In home care or assisted living, the situation is significantly different. The individual or family typically owns the bed, and the home care or assisted living provider cannot legally prohibit them from using rails. However, the provider should try to educate the individual or family about the dangers of side rails and discuss alternatives, which include beds that raise and lower electronically, floor mats, mattresses with raised edges, and secure posts that assist with transfers and repositioning." No other information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On June 15, 2022, at 1:57 p.m. immediacy was removed as confirmed by email correspondence with evaluation supervisor, but non-compliance remains. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20583	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES OF ZUMBROTA	295 WEST 4TH STREET ZUMBROTA, MN 55992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 93 vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20583	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES OF ZUMBROTA	295 WEST 4TH STREET ZUMBROTA, MN 55992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 94	03000		

agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R5) with record reviewed.

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

The findings include:

R5's Progress Notes indicated the following:
-January 24, 2022, at 10:33 a.m. R5 was noted by off duty staff yesterday, walking out of the Covered Bridge Park. The temp was in single digits with wind chill below zero. She told staff yesterday that she was searching in the building for a little girl she thought had left a stuffed animal which she was carrying. She is frequently up wandering in the halls around 4:00 a.m.
-January 27, 2022, at 3:00 p.m. Writer informed family members that at this point residents decline in cognition is jeopardizing her safety and wellbeing with recent elopements outside of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20583	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES OF ZUMBROTA	295 WEST 4TH STREET ZUMBROTA, MN 55992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 95 building in below zero temperatures. Informed family members that a report was made to MAARC due to resident being a vulnerable adult. The licensee provided an email dated January 27, 2022, at 4:03 p.m. sent by registered nurse (RN)-B to RN-C, licensed assisted living director (LALD)-A and two other employees of the licensee "This is the VA [vulnerable adult] report I filed for self-neglect" and indicated resident "left the assisted living about 9 a.m. on the morning of January 25, 2022, to go for a walk. The temp outside was -26, according to a thermometer two blocks north of the building. Staff went to her room to give her meds and she was not there. She was gone for 45 minutes to 1 hour, which is much longer than normal. It is unknown where she was as due to her advanced dementia she can not explain that. She did not sustain any discernable injury." On June 15, 2022, at 9:41 a.m. RN-B stated unlicensed personnel (ULP)-D on January 24, 2022, noticed R5 at the Covered Bridge Park. On June 15, 2022, at 9:41 a.m. RN-C stated, "Yes it is" in regards to the incident being reported three days after the license became aware for the situation. RN-C stated, "The vice president [of the licensee] called me to intervene and I gave direction to report on the 27th." The licensee's Maltreatment Prohibition policy dated August 1, 2021, indicated for guidelines for reporting abuse, if neglect or abuse is suspected a report must be filed immediately (within 24 hours). No further information was provided.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20583	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES OF ZUMBROTA	**295 WEST 4TH STREET ZUMBROTA, MN 55992**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 96 TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Full
Date: *06/14/22*
Time: 10:20:01
Report: 7962221141

Food and Beverage Establishment Inspection Report

Location:
Bridges Of Zumbrota
295 West 4th Street
Zumbrota, MN55992
Goodhue County, 25

Establishment Info:
ID #: 0037752
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5077328455
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 at the specific request of the regulatory authority.

EMPLOYEE ILLNESS LOG, FACT SHEET AND DECISION GUIDE SENT WITH REPORT

Comply By: 06/14/22

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

89DF INDIVIDUAL PACKETS BUTTER, 74DF LARGE CONTAINER OF SELF-SERVE BUTTER FOR RESIDENTS USE EITHER MAINTAIN AT 41DF OR LOWER OR USE TIME AS A PUBLIC HEALTH CONTROL, CONTACT INSPECTOR FOR REQUIRED FORM

Comply By: 06/14/22

5-200B Plumbing: cross connections

5-203.14 ** Priority 1 **

MN Rule 4626.1085A Backflow prevention devices must be installed in accordance with chapter 4714.

MOP SINK THREADED HOSE BIBB AND CHEMICAL CONNECTIONS DO NOT HAVE BACK-FLOW PREVENTION, PICTURE TAKEN

Comply By: 06/14/22

5-200B Plumbing: cross connections

5-203.14A ** Priority 1 **

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

WATER SOFTENER DISCHARGE LINE DOES NOT HAVE AIR GAP, PICTURE TAKEN

Comply By: 06/14/22

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

BOWLS IN SAME SIDE OF BASIN WITH HAND SOAP, DISH TOWEL DRAPED BETWEEN BASINS. DESIGNATE ONE BASIN OF THE TWO COMPARTMENT SINK AS HAND WASHING ONLY, PICTURE TAKEN

Comply By: 06/14/22

5-200C Plumbing: Maintenance, fixture location

5-205.13 ** Priority 2 **

MN Rule 4626.1120 Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.

REDUCED PRESSURE BACK-FLOW IN MECHANICAL ROOM LAST INSPECTED 6-19-20, PICTURE TAKEN

Comply By: 06/14/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-306.12A

MN Rule 4626.0325A Protect condiments from contamination by keeping them in dispensers, protected food displays, or individual packages or portions.

LARGE CONTAINER OF SELF-SERVE BUTTER WITH KNIFE IN IT FOR RESIDENTS USE

Comply By: 06/14/22

4-900 Protecting Clean Items

4-904.11A

MN Rule 4626.0965A Handle, display, and dispense all single-service and single use articles and clean utensils so that contamination of lip-contact and food-contact surfaces is prevented.

BASKET OF SINGLE-USE SPOONS, PICTURE TAKEN

Comply By: 06/14/22

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

CORNER IN KITCHEN EXPOSED METAL AND SHEET-ROCK, PICTURE TAKEN

Comply By: 06/14/22

6-200 Physical Facility Design and Construction

6-202.11A

MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.

ENSURE LIGHTS OVER SERVING AND SELF-SERVICE AREAS ARE SHATTER-RESISTANT

Comply By: 06/14/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.114AB

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

GRILL ON TOP OF CUPBOARDS

Type: Full
Date: *06/14/22*
Time: 10:20:01
Report: 7962221141
Bridges Of Zumbrota

Food and Beverage Establishment Inspection Report

Comply By: 06/14/22

Food and Equipment Temperatures

Process/Item: Domestic Refrigerator
Temperature: 38 Degrees Fahrenheit - Location: ambient air
Violation Issued: No

Process/Item: Out of Refrigeration
Temperature: 89 Degrees Fahrenheit - Location: individual packets of butter
Violation Issued: Yes

Process/Item: Out of Refrigeration
Temperature: 74 Degrees Fahrenheit - Location: large container of self-serve butter for residents use
Violation Issued: Yes

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	4	2	5

Establishment Info:

Person present during inspection:
*Angela Iako-Quinn

Assisted Living Kitchen:

* Served out of kitchen: Breakfast, lunch, dinner, free will snacks
* Food delivered from skilled nursing kitchen
* Same day service only in this kitchen
* All dishes sent to Skilled Nursing kitchen to be washed
* Residents are not allowed in kitchen
* No cooking with stove
* Microwave used for re-heating and cooking

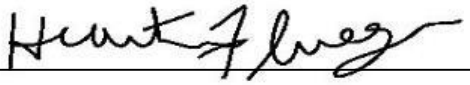
Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7962221141 of 06/14/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____ Signed: 

Establishment Representative

Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us

Report #: 7962221141

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul

No. of RF/PHI Categories Out	3	**Date**	06/14/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	10:20:01
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Bridges Of Zumbrota	295 West 4th Street	Zumbrota, MN	55992	5077328455

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0037752		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39	X	Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45	X	Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51	X	Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56	X	Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 07/06/22

Inspector (Signature) Hunter Flury