DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

July 14, 2023

Licensee
Select Sr Lvg Coon Rapids, LLC
11350 Martin Street Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL25729015

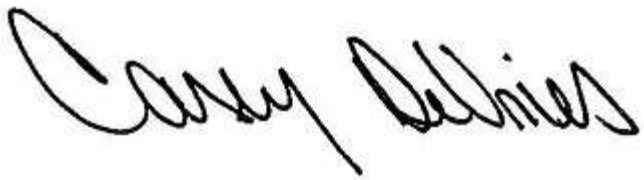
Dear Licensee:

On July 10, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 18, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5719 Fax: 651-281-9796

PMB

Electronically Delivered

June 16, 2023

Licensee
Select Senior Living Coon Rapids LLC
11350 Martin Street Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL25729015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 18, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**

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

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

The correction order documentation should include the following:

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

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

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

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

submit information supporting your position(s).
Please address your cover letter for reconsideration requests to:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25729 | A. BUILDING: _____ B. WING _____ | 05/18/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SELECT SR LVG COON RAPIDS LLC | 11350 MARTIN STREET NW COON RAPIDS, MN 55433 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL25729015-0<br><br>On May 15, 2023, through May 18, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 78 active residents, 67 of whom received services under the Assisted Living Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the | 0 480 | | |

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| 0 480 | Continued From page 1<br>following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents.<br><br>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).<br><br>The findings include:<br><br>Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated May 15, 2023.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 485 SS=C | 144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United | 0 485 | | |

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| 0 485 | Continued From page 2<br><br>States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br>(A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and<br>(C) the facility cannot require a resident to include and pay for meals in their contract;<br>(ii) weekly housekeeping;<br>(iii) weekly laundry service;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to offer at least three nutritious meals daily, according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables and failed to ensure a breakfast menu was prepared a week in advance and provided to the residents. This had the potential to affect all memory care residents.<br><br>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 the residents).<br><br>The findings include:<br><br>On May 15, 2023, at 10:00 a.m., during entrance | 0 485 | | |

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| 0 485 | Continued From page 3 | 0 485 | | |

conference, registered nurse (RN)-A stated the licensee provided three meals per day, served per Minnesota (MN) Food Code.

On May 15, 2023, at 11:47 a.m., the surveyor was provided the meal menu titled May 15 - May 21. The menus lacked at least three nutritious meals daily according to the recommended dietary allowances in the USDA guidelines. The meal menu did not include a breakfast meal to be provided to the residents.

On May 16, 2023, from approximately 6:15 a.m. through 9:30 a.m., the surveyor observed peanut butter toast or instant oatmeal as the only options given for breakfast to all memory care residents. No fruit was offered or served to residents for breakfast.

On May 16, 2023, at 9:25 a.m., unlicensed professional (ULP-G) stated, "We just make them [residents] toast or oatmeal every morning for breakfast. Sometimes they get a hot meal breakfast but typically it is toast or oatmeal. We know what they eat so we just make it for them." When asked about serving fruit ULP-G replied, "No, we don't really give them fruit in memory care."

On May 16, 2023, at 9:35 a.m., clinical nurse supervisor (CNS)-D stated, "That is more of a dietary issue, and I will need to check with them because we offer fresh fruit and boiled eggs with every breakfast. Dietary is supposed to bring down fruit and boiled eggs to the memory care each morning, so I will need to check with them why they are not doing that."

The USDA My Plate: A Guide dated September 1, 2022, indicates half of food plates should include

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| 0 485 | Continued From page 4<br>fruits and vegetables.<br><br>The licensee's Food Service & Menu planning policy dated July 25, 2021, indicated the licensee will offer to provide or make available three meals daily with snacks available seven days per week according to the recommended dietary allowances in the USDA guidelines, including seasonal fruit and fresh vegetables.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for three of three | 0 510 | | |

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| 0 510 | Continued From page 5<br>unlicensed personnel ((ULP)-B, ULP-F and ULP-G). In addition, the licensee failed to ensure staff disinfected shared equipment.<br><br>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).<br><br>The findings include:<br><br>ULP-B<br>On May 16, 2023, from 6:30 a.m. through 7:12 a.m., the surveyor observed ULP-B without gloves, set up medications for R5, knock on door and enter R5's apartment, administer medications to R5, remove full trash bag out of bedroom garbage, exit room, and set trash on floor next to medication cart. Without washing hands, ULP-B proceeded to set up medications for R4, during which time, R7 came out into hallway and asked for medications. ULP-B stopped working with R4's medications, and still without performing hand hygiene, ULP-B set up and administered R7's medications. Without hand hygiene, ULP-B donned gloves, removed eye drops out of the medication cart and picked up the previously filled medication cup to bring into R4's room. ULP-B picked up a spoon and cup from countertop in R4's apartment, dumped out old water from the cup, and filled with fresh tap water. ULP-B assisted R4 with medication administration by spooning pills one by one with yogurt into R4's mouth, and offered water from cup they had filled. ULP-B handed R4 their albuterol inhaler to self-administer, then ULP-B | 0 510 | | |

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| 0 510 | Continued From page 6<br><br>placed a lidocaine patch on R4's front left shoulder, checked R4's blood glucose level with another resident's (R14) blood glucose machine, put machine back in case without cleaning, removed gloves, placed used lancet, blood soiled alcohol pad and tissue inside of gloves, documented blood glucose level on phone, then administered R4's eye drops touching R4's face with left hand to pull lower lid down without gloves. ULP-B placed the spoon in R4's sink and yogurt into R4's refrigerator and exited R4's room. ULP-B discarded thier gloves in the medication cart garbage bin. Without performing any hand hygiene, ULP-B then set up medications for R8, picked up trash bag from floor and set it by R8's room before entering, got water from R8's sink, administered R8's medications, then washed hands in R8's room, upon exiting R8's room, ULP-B picked up trash bag from floor and disposed of it in a room by elevator.<br><br>ULP-F<br>On May 16, 2023, from 6:28 a.m. through 7:04 a.m., the surveyor observed ULP-F enter R2's room and don gloves without performing hand hygiene. ULP-F assisted R2 from bed to wheelchair and escorted R2 into the bathroom where they removed a urine soiled incontinence pad and transferred R2 onto the toilet. ULP-F doffed gloves without performing hand hygiene and assisted R2 with placing a clean brief, pants, TEDS (compression stockings), socks, shirt, and shoes while R2 was sitting on the toilet. Without performing hand hygiene, ULP-F changed gloves and washed R2's face, front and back torso, then donned new gloves without performing hand hygiene and assisted R2 to stand and provided R2 with peri care and applied barrier cream to R2's bottom. ULP-F doffed soiled gloves, pulled up R2's brief and pants and transferred R2 into | 0 510 | | |

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| 0 510 | Continued From page 7 | 0 510 | | |

wheelchair. Without performing hand hygiene, ULP-F donned gloves and assisted R2 with oral cares and hair brushing then doffed gloves and escorted R2 into the living room. ULP-F donned gloves without preforming hand hygiene, made R2's bed then removed garbage from the room. ULP-F then doffed gloves and washed hands in the memory care commons area kitchen sink.

ULP-G
On May 16, 2023, at 7:36 a.m., the surveyor observed ULP-G enter the memory care unit kitchen and wash hands. Without donning gloves, ULP-G placed 4 slices of bread into the toaster. ULP-G then removed toast and placed onto a plate and added peanut butter to each piece of toast. ULP-G then served the toast to a resident and proceeded to wash hands.

On May 16, 2023, at 7:26 a.m., ULP-B stated, "when you are done doing things you use sanitizer. We were trained to sanitize or wash hands after glove removal and before medications." When asked about cleaning of blood glucose machines ULP-B reported staff will use another residents blood glucose machine when someone's machine is missing or they do not have enough test strips. When asked about cleaning the blood glucose machine, ULP-B stated she cleans everything in her cart at the start of her shift, so she knows that it's clean.

On May 16, 2023, at 7:44 a.m., ULP-G stated, "we were trained we need to wear gloves when touching resident's food, I normally do, I was just in a hurry."

On May 16, 2023, at 7:50 a.m., ULP-F stated, "we [staff] are trained that each time you do a care you change your gloves and wash your

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| 0 510 | Continued From page 8<br>hands or when you fix food you wear gloves and wash hands."<br><br>On May 16, 2023, at 7:33 a.m., CNS-D indicated ULPs are expected to wash hands when they go into resident rooms, before donning and after doffing gloves, before and after personal cares, and use hand sanitizer in between when it is not feasible to wash with soap and water.<br><br>On May 16, 2023, at 7:33 a.m.,CNS-D stated all residents have their own blood glucose machines and the facility had some spare machines. If the ULP cannot find the resident's own machine or a spare facility owned machine, the ULPs might use another resident's. CNS-D reported the ULP should use alcohol or sanitizing wrap to clean the borrowed machine after shared use.<br><br>The Centers for Disease Control (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 8, 2021, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled.<br><br>The licensee's Hand washing policy dated August 1, 2021, indicated hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations. When hands should be washed hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: -before and after direct contact with a resident: | 0 510 | | |

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| 0 510 | Continued From page 9<br>-if moving from a contaminated-body site to a clean-body site during resident care;<br>-after contact with environmental surfaces or equipment in the immediate vicinity of the residents;<br>-after removing gloves or gowns;<br>-before, during, and after preparing food;<br>-before and after eating food;<br>-before and after caring for someone who is sick;<br>-before and after treating a cut or wound;<br>-after using the toilet;<br>-after blowing your nose, coughing, or sneezing;<br>-after touching an animal or animal waste;<br>-after handling pet food or pet treats; and<br>-after touching garbage.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 630 SS=D | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(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.<br><br>This MN Requirement is not met as evidenced by: | 0 630 | | |

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| 0 630 | Continued From page 10<br><br>Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R2) reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R2 admitted to the licensee on April 5, 2023, and began receiving assisted living services.<br><br>R2's diagnoses included cerebral infarction, unspecified, cerebral vascular accident (stroke) depressive disorder, gastroesophageal reflux disease, mild persistent asthma, and hypertension (high blood pressure).<br><br>R2's record lacked an individual abuse prevention plan which reviewed the resident's susceptibility to abuse by another individual, including other vulnerable adults; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to those residents and other vulnerable adults.<br><br>On May 16, 2023 at 10:18 a.m., registered nurse (RN)-A stated, "We just completed [R2's IAPP] today; we didn't do it before hand."<br><br>The licensee's Individual Abuse Prevention Plan | 0 630 | | |

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| 0 630 | Continued From page 11<br>policy, dated August 1, 2021, indicated the licensee would develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adult, and the plan would contain an individualized review or assessment of the person's [resident's] susceptibility to abuse by another individual, including other vulnerable adults, the person's [resident'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.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 0 650 SS=D | 144G.42 Subd. 8 Employee records<br><br>(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:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(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 12<br><br>(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<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of three employees (unlicensed personnel (ULP)-F).<br><br>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).<br><br>The findings include:<br><br>ULP-F was hired on March 22, 2023, to provide direct cares and services to the licensee's residents.<br><br>On May 16, 2023, from 6:28 a.m. through 7:04 a.m., the surveyor observed ULP-F provide cares and administer medications to R2.<br><br>ULP-F's record lacked evidence of training on dressing, bathing, hair care, hearing aid use, oral care, toileting assistance, transfer and ambulation techniques, vital signs, administering medications or treatments as required, assistance with eating, preparation of modified diets and thickened | 0 650 | | |

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| 0 650 | Continued From page 13<br><br>liquids, reports of changes in resident condition, basic infection control including handwashing. In addition, ULP-F's record lacked evidence of competencies in dressing, bathing, hair care, hearing aid use, oral care, toileting assistance, transfer and ambulation techniques, vital signs, administering medications or treatments as required.<br><br>On May 17, 2023, at 12:40 p.m., clinical nurse supervisor (CNS)-D acknowledged training and competency evaluations were missing in ULP-F's employee record. CNS-D stated, "There should be a check off form in each employee file from the ones I trained back when I did all the training but now with corporate, we don't have them in the charts. All the staff including her went through all the training, but they just don't send us the check off form like when I did the training here on site, so even though she did all those trainings, I don't have anything to show you that it was done."<br><br>The licensee's Orientation & Training Competency Training Evaluations policy dated August 1, 2021, indicated ULPs must be trained and demonstrate competent ability in the proper methods to perform tasks or procedures before performing those delegated tasks. In addition, the licensee must have a system in place to track availability of competent ULPs.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 660 SS=D | 144G.42 Subd. 9 Tuberculosis prevention and control | 0 660 | | |

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| 0 660 | Continued From page 14<br>(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.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for one of three employees (unlicensed personnel (ULP)-F) with employee records reviewed.<br><br>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).<br><br>The findings include: | 0 660 | | |

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| 0 660 | Continued From page 15<br><br>The Facility TB Risk Assessment dated February 23, 2023, identified the facility was at a low risk for TB transmission.<br><br>ULP-F began employment with the licensee March 22, 2023, to provide assisted living services to the licensee's residents.<br><br>On May 16, 2023, form 6:28 a.m. through 7:04 a.m., the surveyor observed ULP-F assist R2 with cares.<br><br>ULP-F's employee record lacked a baseline TB screening.<br><br>On May 18, 2023, at 10:07 a.m., the surveyor observed a form in ULP-F's employee file. Clinical nurse supervisor (CNS)-D stated ULP-F had submitted to the licensee that form from a school TB test ULP-F had received within 90 days of starting employment with licensee. CNS-D verified the form did not have a symptom screening and that ULP-F did not have a symptom screening in their file. CNS-D stated, "typically when they come from school with that form, we accept that and then we don't have them fill out our symptom screening, all other employees fill out our symptom screening form and I believe there are only two students we have right now that we would not have done the screening for."<br><br>The licensee's Tuberculosis Screening policy dated, August 1, 2021, indicated Staff whose essential job functions require work within the same air space of home care clients [residents] will be screened and tested for tuberculosis prior to the staff being exposed to clients [residents]. Baseline (upon hire) screening will be completed, | 0 660 | | |

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| 0 660 | Continued From page 16<br>but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows:<br>1.New staff will be screened for active signs of TB using the Baseline TB screening tools for the HCW's.<br>2.New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tools for HCW's.<br>3.No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented.<br>4.Staff TB screening results will be kept in each employee medical file.<br><br>The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies | 0 680 | | |

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| 0 680 | Continued From page 17<br>temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have awritten emergency preparedness plan (EPP) available to staff for utilization during an emergency. This had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include: | 0 680 | | |

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| 0 680 | Continued From page 18<br><br>The licensee's EPP dated December 12, 2022, was kept in the licensed assisted living director (LALD)-C office, a location that was not accessible to employees after hours, on weekends, or on holidays.<br><br>On May 15, 2023, at 1:47 p.m., LALD-C indicated the licensee's EPP binder was stored in their locked office, and no one had access to their office after hours.<br><br>The licensee's Emergency Preparedness Program Policies & Procedures Overview policy, dated December 12, 2022, indicated the Emergency Plan guidelines will be developed and made widely available to staff.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 700 SS=F | 144G.43 Subdivision 1 Resident record<br><br>(b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure five of five | 0 700 | | |

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| 0 700 | Continued From page 19<br>resident's (R5, R9, R10, R11, and R12) personal health and medical information was kept private.<br><br>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).<br><br>The findings include:<br><br>On May 18, 2023, at 10:55 a.m. to 11:07 a.m., the surveyor observed an unattended first floor medication cart for 12 minutes with an unlocked computer screen used for accessing resident records for medications and treatments. The screen displayed R5, R9, R10, R11, and R12's full name, unit number, and medication pass times. The surveyor observed four residents and one family member pass directly by the unattended laptop in the hallway.<br><br>On May 18, 2023, at 11:07 a.m., licensed practical nurse (LPN)-E stated unlicensed personnel (ULP) were trained to not leave resident's information on the top of the cart and to lock the computer screen when they are not present. LPN-E stated training occurred at corporate upon hire, in EduCare (computer training software), as well as staff received verbal reminders from them multiple times daily.<br><br>The licensee's Resident Record-Access & Storage policy dated January 7, 2022, indicated all information in the resident record was confidential and all staff were to make sure | 0 700 | | |

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| 0 700 | Continued From page 20<br>confidentiality was maintained for all resident records and information.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 700 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>Findings include: | 0 800 | | |

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| 0 800 | Continued From page 21<br><br>On a facility tour on May 17, 2023, at approximately 12:00 p.m. with licensed assisted living director (LALD)-C and maintenance (M)-I it was observed that the faucet on the tub in the spa was leaking and would not shut off. On the facility tour M-I stated the water needs to be shut off to the whole building in order to repair the faucet.<br><br>It was also observed the trash chute door latches on 1st, 2nd and 3rd floor were in disrepair and would not latch. The trash chute doors are required to close and latch as designed and installed at the time of construction approval.<br><br>On the facility tour it was observed the trash chute termination room door was in disrepair missing the springs and the fusible link was not in place to activate as designed and installed. The trash chute termination room door is required to be maintained as designed and installed to prevent the spread of fire from the trash termination room.<br><br>The fire-resistant rated fire doors leading to the trash room from the garage in the lower level were observed with hinges disconnected, doors held open and not able to close and latch. Fire resistant rated doors in fire resistant rated walls are required to be maintained in order to close and latch as designed and constructed at construction approval.<br><br>A wire penetration in the fire-resistant rated wall of the trash room in the memory care unit was observed without fire caulking to seal. All penetrations in fire resistant rated walls are required to be maintained as designed and constructed at the time of construction approval. | 0 800 | | |

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| 0 800 | Continued From page 22<br><br>An emergency light fixture was observed on, would not shut off and the test function did not work in the facility main dining room. The emergency light fixtures are required to be maintained in order to light the means of egress in the event of a power loss.<br><br>A deck board was observed causing a trip hazard at the top landing of the exterior exit stair at the east side exit door near resident room 108.<br><br>These deficient conditions were visually verified by LALD-C and M-I accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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. | 0 810 | | |

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| 0 810 | Continued From page 23<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>A record review of available documentation and interview were conducted on May 17, 2023, at approximately 10:15 a.m. of documents provided by licensed assisted living director (LALD)-C and maintenance (M)-I on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. | 0 810 | | |

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| 0 810 | Continued From page 24<br><br>Findings include:<br><br>Record review of the available documentation indicated employee actions related to fire safety and evacuation were located in two different documents instead of combined as one document for immediate use. The employee action documents provided need more detailed actions added related to this specific facility.<br><br>Record review of available documentation indicated resident actions were not included in writing in the fire safety and evacuation plan. The resident actions were stated verbally by LALD-C but not included in the plan documentation provided.<br><br>Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees regarding resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs of each resident for movement or evacuation.<br><br>Record review of the available documentation indicated that employees did not receive training on the facility fire safety and evacuation plan upon initial hire and twice per year thereafter. Employee training on the fire safety and evacuation plan is required to be conducted and documented separately from fire evacuation drills.<br><br>Record review of the available documentation indicated that the licensee did not offer training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and | 0 810 | | |

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| 0 810 | Continued From page 25<br>relocation. Written documentation of training of residents in regard to actions required for evacuation is required to be offered once a year.<br><br>All deficiencies were verified by LALD-C and M-I during the interview at approximately 11:15 a.m.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 01290 SS=D | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living with dementia care licensee's current health facility identification (HFID) for one of three employees (unlicensed personnel (ULP-F). | 01290 | | |

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| 01290 | Continued From page 26<br><br>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).<br><br>The findings include:<br><br>ULP-F was hired on March 22, 2023, to perform direct care services to the licensee's residents.<br><br>On May 16, 2023, from 6:28 a.m. through 7:04 a.m., the surveyor observed ULP-F to provide cares and administer medications to R2.<br><br>ULP-F's employee record contained a background study dated March 22, 2023, affiliated with a separate location operated by the licensee's owner under HFID license 25728. ULP-F's employee record lacked evidence of current, cleared background study affiliated with the licensee's current assisted living with dementia care HFID license 25729, effective August 1, 2021.<br><br>The licensee's Background Studies policy dated January 6, 2023, indicated the licensee would conduct a background study on all associates and volunteers and contractors. In addition, all new hires must have a completed background prior to providing direct services or having any independent direct contact with residents.<br><br>No further information was provided.<br><br>TIME PERIOD OF CORRECTION: Two (2) days | 01290 | | |

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| 01370 SS=D | 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn<br><br>(a) Training and competency evaluations for all unlicensed personnel must include the following:<br>(1) documentation requirements for all services provided;<br>(2) reports of changes in the resident's condition to the supervisor designated by the facility;<br>(3) basic infection control, including blood-borne pathogens;<br>(4) maintenance of a clean and safe environment;<br>(5) appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>(6) training on the prevention of falls;<br>(7) standby assistance techniques and how to perform them;<br>(8) medication, exercise, and treatment reminders;<br>(9) basic nutrition, meal preparation, food safety, and assistance with eating;<br>(10) preparation of modified diets as ordered by a licensed health professional;<br>(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;<br>(12) awareness of confidentiality and privacy;<br>(13) understanding appropriate boundaries between staff and residents and the resident's family;<br>(14) procedures to use in handling various emergency situations; and<br>(15) awareness of commonly used health | 01370 | | |

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| 01370 | Continued From page 28<br>technology equipment and assistive devices.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel ((ULP)-F) reviewed.<br><br>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).<br><br>The findings include:<br><br>ULP-F started employment on March 22, 2023, with licensee.<br><br>On May 16, 2023, from 6:28 a.m. through 7:04 a.m., the surveyor observed ULP-F provide cares and administer medications to R2.<br><br>ULP-F's record lacked the following training and competency evaluations:<br>-documentstion requirements for all services provided;<br>- reports of changes in the resident's condition to the supervisor designated by the assisted living provider;<br>- basic infection control, including blood-borne pathogens;<br>- maintenance of a clean and safe environment; | 01370 | | |

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| 01370 | Continued From page 29<br><br>- appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>-training on the prevention of falls for providers working with the elderly or individuals at risk of falls;<br>- standby assistance techniques and how to perform them;<br>- medication, exercise, and treatment reminders;<br>- basic nutrition, meal preparation, food safety, and assistance with eating;<br>- preparation of modified diets as ordered by a licensed health professional;<br>- 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;<br>- awareness of confidentiality and privacy;<br>- understanding appropriate boundaries between staff and residents and the resident's family;<br>- procedures to utilize in handling various emergency situations; and<br>- awareness of commonly used health technology equipment and assistive devices.<br><br>On May 17, 2023, at 12:40 p.m., clinical nurse supervisor (CNS)-D acknowledged training and competency evaluations were missing in ULP-F's employee record. CNS-D stated, "There should be a check off form in each employee file from the ones I trained back when I did all the training but now with corporate, we don't have them in the charts. All the staff including her went through all the training, but they just don't send us the check off form like when I did the training here on site, so even though she did all those trainings, I don't | 01370 | | |

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| 01370 | Continued From page 30<br>have anything to show you that it was done."<br><br>The licensee's Policy 5.02 - Competency Training Evaluations, dated August 1, 2021, indicated the above missing content would be included in training prior to performing tasks.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01370 | | |
| 01380 SS=F | 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn<br><br>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:<br>(1) observing, reporting, and documenting resident status;<br>(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;<br>(3) reading and recording temperature, pulse, and respirations of the resident;<br>(4) recognizing physical, emotional, cognitive, and developmental needs of the resident;<br>(5) safe transfer techniques and ambulation;<br>(6) range of motioning and positioning; and<br>(7) administering medications or treatments as required.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure required competencies were completed for two of two employees (unlicensed personnel (ULP)-B and | 01380 | | |

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| 01380 | Continued From page 31<br>ULP-F).<br><br>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).<br><br>The findings include:<br><br>ULP-B<br>ULP-B began employment with the licensee May 23, 2022, to provide assisted living services to the licensee's residents.<br><br>On May 16, 2023, from 6:30 a.m. through 7:12 a.m., the surveyor observed ULP-B administer medications to R4, R5, R7, and administer medications and assist R8 with repositioning.<br><br>ULP-F<br>ULP-F began employment with the licensee March 22, 2023, to provide assisted living services to the licensee's residents.<br><br>On May 16, 2023, from 6:28 a.m. through 7:04 a.m., the surveyor observed ULP-F provide cares and administer medications to R2.<br><br>ULP-B and ULP-F's employee records lacked the following documentation of required competency training completed by a registered nurse (RN):<br>-range of motioning and positioning.<br><br>On May 18, 2023, at 10:25 a.m., clinical nurse supervisor (CNS)-D stated, "All our aides training | 01380 | | |

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| 01380 | Continued From page 32<br><br>records will have N/A for range of motion because we do not train on that, but our uniform disclosure of assisted living services (UDALSA) says we don't provide that so I was under the impression that we don't need to train on items we don't provide at our facility."<br><br>The licensee's Delegation of Assisted Living Services policy, dated August 1, 2021, indicated, the registered nurse (RN) may delegate nursing services to a person who has successfully completed staff orientation, who has been trained in the service to be provided, and who has demonstrated to the RN the ability to competently follow the procedures for the resident. These services include, but are not limited to:<br>A. Hands-on assistance with transfers and mobility including assisting with body positioning or stand by assistance of a resident, assisting with the resident's mobility, including movement, change of location, and positioning.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01380 | | |
| 01470 SS=F | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(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;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the | 01470 | | |

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| 01470 | Continued From page 33<br>maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(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<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(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:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology | 01470 | | |

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| 01470 | Continued From page 34 | 01470 | | |

that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B, ULP-F) with records reviewed.

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

The findings include:

RN-A
RN-A was hired into the RN role on January 17, 2023, to provide supervision and oversite to unlicensed personnel and provide direct services to residents. RN-A was previously hired in 2021 as an unlicensed personnel (ULP).

On May 15, 2023, at 10:00 a.m., RN-A was observed to be working for the licensee during the survey entrance conference.

RN-A's employee records lacked evidence of orientation to assisted living regulations

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| 01470 | Continued From page 35<br>(144G.63, Sub. 2) effective August 1, 2021, for the following:<br>- an overview of this assisted living statutes;<br>-consumer advocacy service; and,<br>- a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br><br>On May 16, 2023, at 10:18 a.m., RN-A stated, "the training missing from orientation and annual training was training I never did."<br><br>On May 16, 2023, at 10:45 a.m., clinical nurse supervisor (CNS)-D stated, "I am unaware of why [RN-A] did not receive all of her training, when I would do the training on site all the staff received all the required training, now corporate does the training but [LALD] may know more than me."<br><br>On May 16, 2023, at 10:46 a.m., licensed assisted living director (LALD)-C stated, "I will have to look and see if [RN-A] has any more training. I thought we gave you everything."<br><br>ULP-B<br>ULP-B began employment with the licensee May 23, 2022, to provide assisted living services to the licensee's residents.<br><br>On Tuesday, May 16, 2023, from 6:30 a.m. through 7:12 a.m., the surveyor observed ULP-B administer medications to R4, R5, R7, and administer medications and assist R8 repositioning.<br><br>ULP-B's employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following:<br>-handling emergencies and using emergency | 01470 | | |

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| 01470 | Continued From page 36<br>services;<br>-overview of assisted living statutes;<br>-review of provider's policies and procedures;<br>-handling emergencies and using emergency services;<br>-assisted Living bill of rights;<br>-reporting maltreatment of vulnerable adults or minors;<br>-handing of resident complaints, reporting of complaints, where to report;<br>-consumer advocacy services; and<br>-review of types of assisted living services the employee will provide and provider's scope of license.<br><br>On May 16, 2023, at 7:29 a.m., CNS-D indicated training is completed at corporate before staff start working on the floor.<br><br>ULP-F<br>ULP-F began employment with the licensee March 22, 2023, to provide assisted living services to the licensee's residents.<br><br>On May 16, 2023, from 6:28 a.m. through 7:04 a.m., the surveyor observed ULP-F provide cares and administer medications to R2.<br><br>ULP-F's employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following:<br>-Assisted Living Bill of Rights<br><br>On May 17, 2023 at 12:40 p.m., clinical nurse supervisor (CNS)-D acknowledged training and competency evaluations were missing in ULP-F's employee record. CNS-D stated, "There should be a check off form in each employee file from the ones I trained back when I did all the training | 01470 | | |

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| 01470 | Continued From page 37<br>but now with corporate, we don't have them in the charts. All the staff including her went through all the training, but they just don't send us the check off form like when I did the training here on site, so even though she did all those trainings, I don't have anything to show you that it was done."<br><br>The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated, orientation must be completed once for each staff person and would include training on all of the above mentioned items.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01470 | | |
| 01500 SS=F | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor | 01500 | | |

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| 01500 | Continued From page 38<br>blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the | 01500 | | |

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| 01500 | Continued From page 39<br>licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (registered nurse (RN)-A).<br><br>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).<br><br>The findings include:<br><br>RN-A was hired into the RN role on January 17, 2023, to provide supervision and oversite to unlicensed personnel and provide direct services to residents. RN-A was previously hired in 2021 as an unlicensed personnel (ULP).<br><br>RN-A's record lacked evidence annual training had been completed as required in the following areas:<br>-Reporting maltreatment of vulnerable adults or minors;<br>-Assisted Living bill of rights;<br>-Infection control techniques;<br>-Review of provider's policies and procedures; and,<br>-Principles of person-centered planning/service delivery.<br><br>On May 16, 2023, at 10:18 a.m., RN-A stated, "the training missing from orientation and annual training was training I never did."<br><br>On May 16, 2023, at 10:45 a.m., clinical nurse | 01500 | | |

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| 01500 | Continued From page 40<br><br>supervisor (CNS)-D stated, "I am unaware of why [RN-A] did not receive all of her training, when I would do the training on site all the staff received all the required training, now corporate does the training but [licensed assisted living director (LALD)-C] may know more than me."<br><br>On May 16, 2023 at 10:46 a.m., LALD-C stated, "I will have to look and see if [RN-A] has any more training. I thought we gave you everything."<br><br>On May 16, 2023, at 1:42 p.m., licensed assisted living director (LALD)-C stated, "Educare (computer training software) is new to us [licensee] and we didn't realize it wasn't pushing out the annual educations, so [RN-A] and all the staff are currently working on that education, I can keep you posted as they [staff] complete them."<br><br>The licensee's Annual Required Staff Training policy dated August 1, 2021, read, "The following training elements MUST be included every 12 months to all staff who performs direct care services:<br>1. Training on reporting of maltreatment of vulnerable adults under Section 626. 557<br>2. Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights<br>3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental services; and reporting communicable diseases | 01500 | | |

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| 01500 | Continued From page 41<br>4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or Related Disorders<br>5. Review of the facilities policies and procedures relating to the provision of Assisted Living Services and how to implement those policies and procedures<br>6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01500 | | |
| 01530 SS=F | 144G.64 TRAINING IN DEMENTIA CARE REQUIRED<br><br>(a) All assisted living facilities must meet the following training requirements:<br>(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;<br>(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 | 01530 | | |

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| 01530 | Continued From page 42<br>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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review the licensee failed to provide evidence of annual dementia care training on required topics for one of one employee (registered nurse (RN)-A).<br><br>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).<br><br>The findings include:<br><br>The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective May 1, 2023, through April 30, 2024.<br><br>RN-A was hired into the RN role on January 17, 2023, to provide supervision and oversite to unlicensed personnel and provide direct services residents. RN-A was previously hired in 2021 as an unlicensed personnel (ULP).<br><br>RN-A was a full-time employee and worked Monday through Friday. | 01530 | | |

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| 01530 | Continued From page 43<br><br>RN-A's employee record included eight hours of dementia care training completed October 11, 2021, through October 21, 2021. RN-A's employee records lacked the annual dementia care training required.<br><br>On May 16, 2023, at 10:18 a.m., RN-A stated, "the training missing from orientation and annual training was training I never did."<br><br>On May 16, 2023, at 1:42 p.m., licensed assisted living director (LALD)-C stated, "Educare (computer training software) is new to us [licensee] and we didn't realize it wasn't pushing out the annual educations, so [RN-A] and all the staff are currently working on that education, I can keep you posted as they [staff] complete them."<br><br>The licensee's Dementia Training policy, dated August 1, 2021, indicated Supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date, and all staff will complete two (2) hours of additional training for each 12 months of work thereafter.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 01760 SS=D | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the | 01760 | | |

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| 01760 | Continued From page 44<br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure medication administration was documented accurately in the medication administration record (MAR) for one of six residents (R4).<br><br>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).<br><br>The findings include:<br><br>R4's diagnoses included, but were not limited to, type 2 diabetes, major depressive disorder, and hypertension.<br><br>R4's service plan dated November 1, 2022, indicated R4 received services which included medication administration. | 01760 | | |

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| 01760 | Continued From page 45<br><br>On May 16, 2023, at 6:45 a.m., the surveyor observed unlicensed personnel (ULP)-B administer vitamin D 50 microgram (mcg), omeprazole 20 milligram (mg), metformin hydrochloride (hcl) 500 mg, lisinopril 5 mg, fluoxetine hcl 40 mg, CertaVite/ Antioxidants 1 tablet, bupropion hcl extended release (ER) 300 mg, aspirin 81 mg cap, acetaminophen 1000 mg, lidocaine 4 percent (%) patch, propylene glycol 0.6 % solution eye drops, Qvar RediHaler 80 mcg / ACT AERB inhaler one puff to R4. ULP-B left R4's room and returned to the medication cart. ULP-B did not document administration of R4's medications. Next, at 7:00 a.m., ULP-B set up medications for R8, proceeded to R8's room and administered the medications, then return to the medication cart, and documented administration of R8's medications. ULP-B left R8's room at 7:12 a.m., and proceeded to the dining room to order breakfast for several residents that planned to eat in their rooms. Surveyor interviewed ULP-B in the dining room while ULP-B was waiting for kitchen staff from 7:12 a.m. until 7:28 a.m.<br><br>On May 16, 2023, at 7:25 a.m., during above noted interview, the surveyor inquired why R4's medications were not documented on after administration. ULP-B stated they had signed off the medications right after administration.<br><br>On May 16, 2023, at 7:30 a.m., clinical nurse supervisor (CNS)-D indicated ULPs should document medication administration in the MAR immediately after administration has been completed. CNS-D stated, "typically they should be marking them [medication] as they give out. Occasionally they will forget and then they can go in an override it." During the interview with CNS-D, the licensed practical nurse (LPN)-E | 01760 | | |

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| 01760 | Continued From page 46<br>verified R4's Medication Administration Record (MAR) dated May 2023 lacked documentation of administration of the above medication being administered on May 16, 2023.<br><br>The licensee's Medications & Treatments policy 7.08 Medication Management- Administration & Setup dated August 01, 2021, indicated documentation for all tasks would be completed immediately after the task had been performed.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 01790 SS=D | 144G.71 Subd. 10 Medication management for residents who will<br><br>(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;<br>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and<br>(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.<br>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:<br>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed | 01790 | | |

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| 01790 | Continued From page 47<br>staff is competent to follow the procedures for giving medications to residents; and<br>(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:<br>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;<br>(ii) how the container or containers must be labeled;<br>(iii) written information about the medications to be provided;<br>(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;<br>(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;<br>(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<br>(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.<br><br>This MN Requirement is not met as evidenced by: | 01790 | | |

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| 01790 | Continued From page 48<br><br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented training and/or competencies for one of two unlicensed personnel ((ULP)-F) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available.<br><br>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).<br><br>The findings include:<br><br>ULP-F was hired March 22, 2023, to provide direct cares and services to the licensee's residents.<br><br>On May 16, 2023, from 6:28 a.m. through 7:04 a.m., the surveyor observed ULP-F provide cares and administer medications to R2.<br><br>ULP-F's employee record included medication training completed at a corporate location on April 10, 2023, and a 30-Day New Employee Supervision of Unlicensed Personnel dated April 19, 2023. ULP-F's record lacked documentation they had been trained and found competent to provide medications to residents who may have an unplanned time away from home.<br><br>On May 17, 2023, at 2:00 p.m., clinical nurse supervisor (CNS)-D stated employees who administered medications should be trained on | 01790 | | |

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| 01790 | Continued From page 49<br><br>the licensee's planned and unplanned time away procedure. CNS-D verified ULP-F's record lacked unplanned time away training and competency. CNS-D showed the surveyor a form the licensee used for training and competency for unplanned time away at the facility and stated ULP-F was trained at corporate and ULP-F's training did not include unplanned time away.<br><br>The licensee's Medication Management - Planned & Unplanned time away policy dated August 1, 2021, indicated, for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or properly trained and competency tested unlicensed personnel may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven (7) calendar days.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01790 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to store prescription medication securely and permit only authorized personnel to have access for two of eleven | 01880 | | |

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| 01880 | Continued From page 50<br>memory care residents (R2, R3)<br><br>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).<br><br>The findings include:<br><br>On May 16, 2023, at 6:52 a.m., the surveyor observed one tube of Baza cream 12 percent (%) and 1 bottle of nystatin powder in R2's bathroom.<br><br>On May 16, 2023, at 741 a.m., the surveyor observed one half full open bottle of over-the-counter aspirin 81 mg with an unknown number of tablets in R3's room.<br><br>R2 and R3's individualized medication management plans dated April 5, 2023, and May 3, 2023 respectively, indicated staff provided all medications to residents and all medications were securely stored in a locked medication cart.<br><br>On May 16, 2023, at 7:09 a.m., unlicensed personnel (ULP)-F stated, "we always leave powders and creams in the resident's bathrooms because we put those items on each time the resident goes to the bathroom, or for other residents, hospice might need to use it, so we keep them in all the bathrooms of those who have creams or powders."<br><br>On May 16, 2023, at 7:58 a.m., clinical nurse supervisor (CNS)-D stated, "there should not be any medications what-so-ever left in any resident | 01880 | | |

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| 01880 | Continued From page 51<br>room in the memory care. Those medications should all be locked up in the medication carts."<br><br>The licensee's Medication Storage policy, dated August 1, 2021, indicated that medications will be stored consistent with each residents' medication management plan and service plan.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened for one of three residents (R1). In addition, the licensee failed to ensure to discard expired medication for two of six residents (R5 and R15).<br><br>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 | 01890 | | |

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| 01890 | Continued From page 52<br>a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>TIME SENSITIVE MEDICATION<br>On May 16, 2023, at 7:30 a.m., the surveyor observed the contents of the memory care unit medication cart labeled "MC1", which contained one bottle of fluticasone spray 50 micrograms (mcg) for R1 with no open date/expired date label.<br><br>EXPIRED MEDICATIONS<br>On May 16, 2023, at approximately 11:00 a.m., the surveyor observed the first-floor medication cart contents and observed the following expired medications:<br>- R5, One card with 12 pills of Senna 8.6 milligram (mg) tablets - expired August 31, 2021; and<br>- R15, One card with 6 pills of Senna-S 8.6- 50 milligram (mg) tablets - expired September 30, 2022.<br><br>On May 16, 2023, at approximately 11:15 a.m., clinical nurse supervisor (CNS)-D stated the ULPs should notify the nurses when there are expired medications that need to be removed from the cart. CNS-D could not tell when the medication cart was last audited.<br><br>On May 16, 2023, at 7:47 a.m., unlicensed personnel (ULP)-G stated they were trained to add a date open sticker to any bottles they open.<br><br>On May 16, 2023, at 7:57 a.m., CNS-D stated, "The staff are trained they need to put a date open sticker on the container as soon as they open them. [LPN-E] our licensed practical nurse | 01890 | | |

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| 01890 | Continued From page 53<br>goes around and checks them often to ensure they are doing it."<br><br>The manufacturer's guidelines for fluticasone nasal spray 50 mcg dated November 21, 2022, indicated, "The correct amount of medication in each spray cannot be assured after 120 sprays even though the bottle is not completely empty. The bottle should be discarded when the labeled number of actuations has been used."<br><br>The licensee's Medication - Prescription Drugs & Prohibition policy dated January 10, 2022, indicated prescription medications would contain an expiration date or beyond-use date of a time-dated drug.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01940 SS=F | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>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:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy | 01940 | | |

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| 01940 | Continued From page 54<br>administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content and failed to include all treatments or therapies ordered for one of three residents (R2).<br><br>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).<br><br>The findings include:<br><br>R2 admitted to the licensee on April 5, 2023, and began receiving assisted living services. | 01940 | | |

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| 01940 | Continued From page 55<br><br>R2's diagnoses included cerebral infarction, unspecified, cerebral vascular accident (stroke) depressive disorder, gastroesophageal reflux disease, mild persistent asthma, and hypertension (high blood pressure).<br><br>R2's Service Plan Detail signed April 5, 2023, indicated R2 received AM cares, linen change, PM cares, biweekly shower, bed making, laundry, housekeeping, medication administration, escorts, toileting, and safety checks.<br><br>On May 16, 2023, between 6:28 a.m., and 6:52 a.m., the surveyor observed ULP-F assist R2 with AM cares including assisting with putting on TEDS.<br><br>R2's provider order singed April 3, 2023, indicated R2 received blood sugar checks three times a week before breakfast, one time a day every Monday, Wednesday, and Friday, diabetic foot checks every evening shift, CPAP settings at 8cm H2O. On at HS [hour of sleep] off in AM. Per home settings for breathing, and incentive spirometer at least ten times during awake hours every day and evening shift.<br><br>R2's Treatment and Therapy Management Plan dated April 5, 2023, indicated R2 did not receive any treatments or therapy.<br><br>R2's EMAR dated May 1, 2023, through May 31, 2023, included TEDS (compression stockings) on in the morning, apply TEDS in the morning to bilateral lower extremities. For: edema, and TED hose off at HS (hour of sleep), remove TED stockings at HS. Rinse out with soap and water and hang dry. R2's EMAR did not include any information related to the CPAP or incentive | 01940 | | |

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| 01940 | Continued From page 56<br>spirometer.<br><br>R2's signed service plan dated April 5, 2023, and electronic medication administration record (EMAR) dated May 1, 2023, through May 31, 2023, included parts of the individualized treatment management plan. The individualized treatment management plan lacked procedures for staff to notify an RN when problems arose.<br><br>On May 16, 2023, at 9:32 a.m., clinical nurse supervisor (CNS)-D stated they had confirmed that all treatment plans for residents who had TEDS lacked procedures for staff to notify an RN when problems arose. CNS-D stated treatment plans were completed for all those that need one, and that they may have missed this one treatment plan.<br><br>On May 17, 2023, CNS-D stated, "[R2's] husband handles her CPAP, he does all of that. I no longer have the assessment that I completed for the CPAP though. Again, her husband completes that, but we do not have anything for documentation that shows the husband manages the CPAP completely. As for the incentive spirometer and the blood glucose and other items, those have been discontinued, but I can't seem to find the order for discontinuing them so I will have the doctor sign one today."<br><br>The licensee's Treatment and Therapy Management Plan policy dated, August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which would include procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services. | 01940 | | |

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| 01940 | Continued From page 57<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |
| 02040 SS=F | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements:<br>(1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). | 02040 | | |

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| 02040 | Continued From page 58<br><br>Findings include:<br><br>A record review of available documentation and interview were conducted May 17, 2023, at approximately 11:00 a.m. with licensed assisted living director (LALD)-C and maintenance (M)-I on the hazard vulnerability assessment for the physical environment of the facility.<br><br>Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around this specific facility physical environment and site. A general HVA was performed but did not contain specifics to this facility and site and did not contain hazard mitigations.<br><br>This deficient condition was verified by LALD-C and M-I during the interview at approximately 11:30 a.m.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 02040 | | |
| 02320 SS=D | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by: | 02320 | | |

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| 02320 | Continued From page 59<br><br>Based on observation, interview, and record review the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for one of four employees (ULP-B) observed during medication administration.<br><br>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).<br><br>The findings include:<br><br>Licensee's medication related training included the following rights of medication passing:<br>- Right resident;<br>- Right medication;<br>- Right date;<br>- Right time;<br>- Right route; and<br>- Right dose.<br><br>ULP-B started employment with licensee on May 23, 2022, and started providing assisted living services.<br><br>On June 6, 2022, ULP-B attended training presented by CNS-D. The training included 118 pages of specific education and competency demonstration on medication administration and delegated tasks. All of ULP-B's medication related competencies were completed by CNS-D on June 6, 2022. | 02320 | | |

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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 |
|---|---|---|---|---|
| 02320 | Continued From page 60<br><br>On May 16, 2023, at 6:40 a.m., the surveyor observed ULP-B punch/remove vitamin D (Cholecalciferol) 50 micrograms (mcg), omeprazole 20 milligrams (mg), metformin hydrochloride (hcl) 500 mg, lisinopril 5 mg, fluoxetine hcl 40 mg, CertaVite/ antioxidants 1 tablet, bupropion hcl ER 300 mg, aspirin 81 mg, and acetaminophen 1000 mg from medication bubble cards and removed lidocaine 4 percent (%) patch, propylene glycol 0.6 % SOLN eye drops, Qvar RediHaler 80 mcg / ACT AERB inhaler from medication cart without verifying medications against the medication administration record (MAR). During the process, R7 approached the medication cart and requested their medications. ULP-B stopped preparation of R4's medication pass. ULP-B then punched vitamin d3 25 mg, lisinopril 15 mg, Citracal Petites 200mg - 250 mg from medication cards without verifying medications against the MAR and administered to medication to R7. ULP-B then went to R4's room and administered the medications listed above. ULP-B administered R4 and R7's medications without following the rights of medication administration.<br><br>On May 16, 2023, at 6:59 a.m., the surveyor observed ULP-B punch simvastatin 40 mg, farxiga 5 mg, vitamin D 50 mcg, CeroVite tablets 1 tablet, lisinopril 10 mg, glipizide er 5 mg, folic acid 800 mcg, and aspirin 325 mg from medication cards without verifying medications against the MAR. ULP-B then went into R8's room and administered the medications listed above without following the rights of medication administration.<br><br>On May 16, 2023, at 8:45 a.m. the surveyor observed ULP-B punch divalproex 500 mg, donepezil 5 mg, hydralazine 50 mg, lisinopril 20 | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25729 | A. BUILDING: _____ B. WING _____ | 05/18/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SELECT SR LVG COON RAPIDS LLC | 11350 MARTIN STREET NW COON RAPIDS, MN 55433 |

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|---|---|---|---|---|
| 02320 | Continued From page 61<br><br>mg, reguloid 0.52 g, acetaminophen 1000 mg, and vitamin B12 1000 mcg from medications cards without verifying medications against the MAR. ULP-B then punched out three more unidentified medications into another medication cup without verifying against the MAR. ULP-B then went into R9 and R10's shared room and administered the first cup of medications to R9. R10 was not in the room at the time and ULP-B brought the second medication cup and a glass of water to the licensed assisted living director's office where R10 was located, waited outside the office until he left, and then administered the second cup of unidentified medications to R10 without following the rights of medication administration.<br><br>On May 16, 2023, at 7:15 a.m., ULP-B stated they took a corporate class for medication administration at another building. In addition, ULP-B stated after the class form corporate, they were shadowed by another ULP who passed medication for seven days and then the nurse shadowed them for the last two days of training to sign them off as a ULP who could pass medication. The surveyor inquired how they were trained to ensure accurate medications were given to residents. ULP-B stated they received training on the rights and comparing the medication cards against medication orders three times for accuracy during medication set up. In addition, ULP-B stated they should have put papers with names into cups when she sets up for more than one person.<br><br>On May 16, 2023, at 7:29 a.m., clinical nurse supervisor (CNS)-D stated ULPs were trained and completed competencies on medication administration by corporate at another facility. After corporate training the new ULP shadowed a | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25729 | A. BUILDING: _____ B. WING _____ | 05/18/2023 |

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|---|---|---|---|---|
| 02320 | Continued From page 62<br><br>ULP who passed medication in the licensee's building for six shifts and during the last two shifts the ULP would complete a medication pass with the experienced ULP watching their medication passes. On the ULP's seventh shift, the ULP is observed by RN-A. CNS-D verified the ULPs received training on the rights of medication administration and verifying medication against the MAR for accuracy. In addition, CNS-D stated, "typically, they check the name expiration date against the computer, and they check the time against the MAR to the card."<br><br>On May 16, 2023, at 8:55 a.m. LPN-E stated ULPs, "should never, ever, ever set up medications for more than one person at a time."<br><br>The licensee's policy Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated the ULP would be instructed by an RN and complete a competency on the completed procedure of checking a resident's MAR, the preparation of medication for administration, the administration of the medication to the resident, and the documentation after assistance with medication reminders and assistance of the date, time, dosage, and method of administration for all medications, or the reason for not assisting with medication administration as ordered.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02320 | | |
| 02350 SS=F | 144G.91 Subd. 7 Courteous treatment<br><br>Residents have the right to be treated with | 02350 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25729 | A. BUILDING: _____ B. WING _____ | 05/18/2023 |

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|---|---|---|---|---|
| 02350 | Continued From page 63<br>courtesy and respect, and to have the resident's property treated with respect<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure resident's property was treated with courtesy and respect when staff used a resident's blood glucose machine (R14) to check blood sugar readings for another resident (R4) observed during medication pass.<br><br>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).<br><br>The findings include:<br><br>On May 16, 2023, at 6:40 a.m., the surveyor observed ULP-B check R4's blood glucose level with another resident's (R14) blood glucose machine, put machine back in case without cleaning, and return the case to the medication cart.<br><br>On May 16, 2023, at 7:26 a.m., when asked about cleaning of blood glucose machines, ULP-B reported staff will use another resident's blood glucose machine when someone's machine is missing or they do not have enough test strips. When asked about cleaning the blood glucose machine, ULP-B stated she cleans everything in her cart at the start of her shift, so she knows that | 02350 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 25729 | A. BUILDING: _____ B. WING _____ | 05/18/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 02350 | Continued From page 64<br>it's clean.<br><br>On May 16, 2023, at 7:33 a.m., CNS-D stated all residents have their own blood glucose machines and the facility had some spare machines. If the ULP cannot find the resident's own machine or a spare facility owned machine, the ULPs might use another resident's machine. CNS-D reported the ULP should use alcohol or sanitizing wrap to clean the borrowed machine after shared use.<br><br>The licensee's policy dated August 1, 2021, titled Blood Sugar Testing- Shared Equipment Use did not differentiate between shared facility owned equipment or property owned by another resident.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02350 | | |

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

Type: Full
Date: *05/15/23*
Time: 12:50:00
Report: 1013231134

# Food and Beverage Establishment Inspection Report



**Location:**
Select Sr Lvg Coon Rapids Llc
11350 Martin Street Nw
Coon Rapids, MN55433
Anoka County, 02

**Establishment Info:**
ID #: 0038523
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 7637671127
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.

**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.

3 CONTAINERS OF MILK WERE STORED IN AN ICE BATH AT ROOM TEMP DURING LUNCH SERVICE. THE MILK MEASURED 55F AND THE ICE BATH CONTACTED THE BOTTOM 1/2 INCH OF THE MILK CONTAINERS. COMPLY WITH RULE. DISCUSSED MECHANICAL REFRIGERATION AND FOOD MOVED TO COOLER.

*Comply By: 05/15/23*

**5-200B Plumbing: cross connections**

***5-203.14I*** ***** Priority 1 *****

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

Y-VALVE WITH SHUTOFFS WAS CONNECTED TO THE MOP SINK FAUCET ON THE DISCHARGE SIDE OF THE ATMOSPHERIC VACUUM BREAKER. A CHEMICAL DISPENSER AND A LONG HOSE BELOW THE SPILL RIM WERE CONNECTED. COMPLY WITH RULE. PROVIDED MDH GUIDANCE SHEET.

*Comply By: 05/15/23*

**4-300 Equipment Numbers and Capacities**

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

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

QUATERNARY AMMONIUM SANITIZER IS USED AT THE FACILITY. NO QUAT TEST KIT WAS AVAILABLE. COMPLY WITH RULE.

*Comply By: 05/19/23*

**6-300 Physical Facility Numbers and Capacities**

***6-301.12*** ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO PAPER TOWELS OR HAND DRYING DEVICE WAS AVAILABLE AT THE SERVICE KITCHEN HAND WASHING SINK. THE DISPENSER WAS EMPTY. COMPLY WITH ABOVE RULE. STAFF STOCKED PAPER TOWELS.

*Corrected on Site*

**7-100 Toxic Labeling**

***7-102.11*** ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

SPRAY BOTTLE CONTAINING A RED SUDSY LIQUID WITHOUT A LABEL WAS STORED IN THE SERVICE KITCHEN. STAFF WERE NOT SURE WHAT THE PRODUCT WAS. COMPLY WITH ABOVE RULE. CHEMICAL WAS DISCARDED.

*Corrected on Site*

**Surface and Equipment Sanitizers**

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizer dispenser
Violation Issued: No

Hot Water: = at 175 Degrees Fahrenheit
Location: Dish machine 1
Violation Issued: No

Hot Water: = at 163 Degrees Fahrenheit
Location: Dish machine 2
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Roast beef
Temperature: 39 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Cheese
Temperature: 37 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Pasteurized eggs
Temperature: 37 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Type: Full
Date: *05/15/23*
Time: 12:50:00
Report: 1013231134
Select Sr Lvg Coon Rapids Llc

# Food and Beverage Establishment Inspection Report

Process/Item: Cheese
Temperature: 40 Degrees Fahrenheit - Location: Tall cooler
Violation Issued: No

Process/Item: Hard boiled eggs
Temperature: 40 Degrees Fahrenheit - Location: 2 door cooler
Violation Issued: No

Process/Item: Ham
Temperature: 38 Degrees Fahrenheit - Location: 2 door cooler
Violation Issued: No

Process/Item: Soup
Temperature: 152 Degrees Fahrenheit - Location: Warmer
Violation Issued: No

Process/Item: Mac and cheese
Temperature: 19 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

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

The inspection was completed with the operator and discussed with MDH Nursing Evaluator T. Brown.

Discussed cleaning, ware washing, sanitizer, temperature control, final cook temperatures, serving highly susceptible populations, and food handling procedures.

**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 1013231134 of 05/15/23.

Certified Food Protection Manager: Elizabeth Johnson

Certification Number: 90958 Expires: 04/17/26

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
Jeremy Schouveller
Regional Culinary Director

Signed: JM
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us