Electronically delivered

April 26, 2023

Licensee
Royal Age Assisted Living, LLC
7047 Goodview Avenue South
Cottage Grove, MN 55016

RE: Project Number(s) SL36630015

Dear Licensee:

On December 9, 2022, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 20, 2022. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 20, 2022 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on July 20, 2022, found not corrected at the time of the December 9, 2022, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - $500
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - $500

The details of the violations noted at the time of this follow-up survey completed on December 9, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000**. 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.

IMPOSITION OF FINES:

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

§144G.20.

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

We urge you to review these orders carefully. If you have questions, please contact Jonathan.Hill@state.mn.us.

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

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36630	A. BUILDING: _____ B. WING _____	R 12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL AGE ASSISTED LIVING LLC	7047 GOODVIEW AVENUE SOUTH COTTAGE GROVE, MN 55016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project 36630015-2 On December 9, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 26, 2022. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are	{0 470}		

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{0 470}	Continued From page 1 available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action required	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required	{0 480}		
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying	{0 490}		

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{0 490}	Continued From page 2 information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: No further action required	{0 490}		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	{0 640}		

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{0 640}	Continued From page 3 No further action required	{0 640}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required	{0 650}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	{0 780}		

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{0 780}	Continued From page 4 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the required interconnection of the smoke alarm in resident bedroom #5 (next to the entrance door) with the home's smoke alarm system. This has the potential to directly affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	{0 780}		

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{0 780}	Continued From page 5 The findings include: On December 9, 2022, approximately from 2:45 p.m. to 3:15 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A and the licensed assisted living director (LALD)-B. During the home tour, LALD-B tested the newly installed smoke alarm inside the first-level resident bedroom #5 (near the entrance door) and the alarm failed to sound all smoke alarms in the home as required for the interconnection of all smoke alarms. The finding was evident when the smoke alarm in resident room #5 was tested and it sounded local. Survey staff explained to the LALD-A and the LALD-B that the new smoke alarm installed inside bedroom #5 must be interconnected to the home's smoke alarm system such that when one alarm is activated, all smoke alarms sound immediately in the home for notification. The LALD-B stated he thought the new smoke alarm did not have to be interconnected. On December 9, 2022, at approximately 3:15 p.m., the survey staff explained the findings to the LALD-A and the LALD-B, and they acknowledged the above findings. No further information was provided.	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	{0 800}		

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{0 800}	Continued From page 6 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of residents. This had the potential to directly affect occupied residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On December 9, 2022, approximately from 2:45 p.m. to 3:15 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A and the licensed assisted living director (LALD)-B. During the home tour, survey staff observed the following: 1. The window for the first-level resident bedroom # 5 (vacant room next to the entrance door) had not been replaced or repaired to meet the minimum size egress window opening required for safe egress in accordance with state standards. Survey staff asked about the progress of the egress window replacement in bedroom #5. The LALD-B and LALD-A explained they had	{0 800}		

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{0 800}	Continued From page 7	{0 800}		

secured a quote from a contractor and can forward the quote to survey staff for review. The LALD-B asked if one or both windows had to be replaced to meet egress and survey staff clarified again that only one window in the bedroom must meet egress window openings. At least one window in the bedroom must meet the state standard minimum existing window opening size of at least 20 inches in height and a minimum width of 20 inches with a total of at least 648 square inches (4.5 square feet) required for egress window openings for bedrooms.

In addition, survey staff also asked the LALD-A if bedroom (#5) was currently being occupied by a resident since survey staff observed the bedroom had a bed, personal belongings, and a wheelchair compared to the last time survey staff was on site (September 26, 2022) where it was used for storage. The LALD-A explained that she currently was getting the room ready for a future client that was in transition care and will relocate to the home and intents on using this room for the new client. Survey staff explained to the LALD-A the bedroom must not be occupied by a resident until one of the windows in bedroom #5 is replaced to meet egress window openings for safe egress.

2. The exhaust fan cover in the bathroom of resident room #1 (upper-level master) was still layered with thick dust and debris and had not been cleaned. The LALD-A confirmed the finding.

3. The window in bedroom # 1 (upper-level master) had a large crack. The LALD-A stated they are also getting this window repair and had received a quote from a contractor.

On December 9, 2022, at approximately 3:20 p.m., the survey staff explained the findings to the

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{0 800}	Continued From page 8 LALD-A and the LALD-B, and they acknowledged the above findings. Survey staff reminded the LALD-A and LALD-B for the documentation to show the repair quotes and schedule of window work. The LALD-B stated that he had just send the documentation via email. Additional information was received via email from the licensee on Friday, December 9, 2022, at 3:20 p.m. with attached quote documentation dated November 9, 2022 (bedroom #5), and November 10, 2022 (bedroom #1). No schedule of work was submitted.	{0 800}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders;	{01370}		

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{01370}	Continued From page 9 (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further action required	{01370}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and	{01380}		

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{01380}	Continued From page 10 (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: No further action required	{01380}		
{01470} SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	{01470}		

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{01470}	Continued From page 11 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required	{01470}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL AGE ASSISTED LIVING LLC	7047 GOODVIEW AVENUE SOUTH COTTAGE GROVE, MN 55016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01880}	Continued From page 12 No further action required	{01880}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action required	{01910}		

Electronically delivered

October 19, 2022

Administrator
Royal Age Assisted Living, LLC
7047 Goodview Avenue South
Cottage Grove, MN 55016

RE: Project Number(s) SL36630015

Dear Administrator:

On September 26, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on July 20, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the July 20, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on July 20, 2022, found not corrected at the time of the September 26, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) = $500
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) = $500
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) = $500

The details of the violations noted at the time of this follow-up evaluation completed on September 26, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

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

Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

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

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

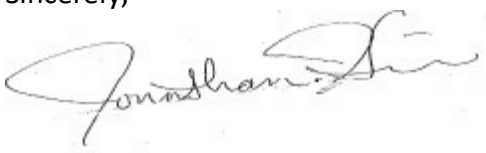
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd.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

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

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

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

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL AGE ASSISTED LIVING LLC	7047 GOODVIEW AVENUE SOUTH COTTAGE GROVE, MN 55016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95 these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. SL36630015-1 On September 26, 2022, a surveyor with the Minnesota Department of Health conducted a follow-up survey to verify correction of order(s) issued at the time of the July 20, 2022, licensing survey. As a result of the follow-up survey, the following order have been reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}		

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{0 470}	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action required.	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	{0 480}		

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{0 480}	Continued From page 2 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon	{0 490}		

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{0 490}	Continued From page 3 individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: No further action required.	{0 490}		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: No further action required.	{0 640}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:	{0 650}		

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{0 650}	Continued From page 4 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: No further action required.	{0 650}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in	{0 780}		

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{0 780}	Continued From page 5	{0 780}		

the State Fire Code:
(i) provide smoke alarms in each room used for sleeping purposes;
(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;
(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;
(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and
(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to provide the required interconnection and the minimum number of smoke alarms in the home. This has the potential to directly affect residents, staff, and visitors.

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

The findings include:

On September 26, 2022, approximately from

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{0 780}	Continued From page 6 noon to 1:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following findings: MISSING SMOKE ALARMS The first-level resident room #5 (near the entrance door) was not provided with the required smoke alarms. INTERCONNECTION OF SMOKE ALARMS The testing of smoke alarms failed to sound all smoke alarms in the home as required for the interconnection of all smoke alarms. The finding was evident when the smoke alarms in resident rooms located on the upper-level floor, # 1, #2, and #3 were tested and sounded, but the smoke alarms in bedroom #4, the hallway on the upper level, and the basement failed to sound. Survey staff explained to the LALD-A that all required smoke alarms in the home including the unfinished basement must be interconnected such that when one alarm is activated, all smoke alarms sound immediately in the home for notification. On September 26, 2022, at approximately 1:30 p.m. during the exit interview, the survey staff explained the findings to the LALD-A. The LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	{0 790}		

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{0 790}	Continued From page 7 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{0 800}		

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{0 800}	Continued From page 8 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings are: On September 26, 2022, approximately from noon to 1:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following findings: 1) The double-hung windows for the vacant first-level resident room # 5 (next to the entrance door) opened at a maximum height of 4 inches with a width of 20 inches and did not open fully to provide a clear opening area of at least 20 inches in height due to screws installed on each side of the windows. Survey staff explained to the LALD-A that window openings for this room still did not meet the minimum size egress window opening required for safe egress, and at least one window in the bedroom must meet the state standard minimum existing window opening size of at least 20 inches in height and a minimum with of 20 inches with a total of at least 648 square inches (4.5 square feet) required for egress window openings for bedrooms. The LALD-A commented that her husband has been trying to work on the repair and they may consider using this room as an office only. The licensee lacked documentation for a maintenance plan or schedule for repairs for an egress window in resident room #5.	{0 800}		

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{0 800}	Continued From page 9 2) The windows in resident bedrooms #1, #2, and #3 were missing screens to prevent unwanted insects and added protection for residents. 3) The exhaust fan cover in the bathroom of resident room #1 (upper-level master) was layered with thick dust and debris. 4) In the unfinished basement, a sanitary sump serving the laundry sink was still observed without a secured gastight cover. Survey staff pointed to the LALD-A that the cover was still sitting in the area. 5) The water heater in the unfinished basement was missing a discharge pipe from the pressure relief valve. No documentation for a maintenance plan or schedule for the missing pipe. 6) The first-level bathroom sliding door was still loose and not secured to the base. This posed a safety concern to the residents and employees when opening and closing the door. An attempt was made to repair the sliding door but it was still loose and not secured properly. On September 26, 2022, at approximately 1:30 p.m. during the exit interview, the survey staff explained the findings to the LALD-A. The LALD-A verified and acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	{0 810}		

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{0 810}	Continued From page 10 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based record review, and interview, the licensee failed to provide the required training on fire safety and evacuation plan and the minimum number of evacuation drills. This has the potential	{0 810}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL AGE ASSISTED LIVING LLC	7047 GOODVIEW AVENUE SOUTH COTTAGE GROVE, MN 55016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 810}	Continued From page 11 to directly affect the safety of all residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 26, 2022, at approximately 1:00 p.m., survey staff requested and interviewed the LALD-A about recent employee fire and evacuation drill performed and the employee training documentation. 1) No record of employee training on the fire safety and evacuation plan for the home was provided for review. Survey staff explained to the LALD-A that the minimum required employee training is upon hire and twice a year specifically for fire safety and evacuation plan and that the fire safety and evacuation training was in addition to the annual required emergency preparedness plan training. 2) No evacuation drill record was provided for review showing compliance with the fire and evacuation drills performed as required by the facility policy dated August 1, 2021, and Minnesota Statutes for assisted living. On September 26, 2022, at approximately 1:30 p.m. during the exit interview, the survey staff explained the above findings to the LALD-A. The LALD-A acknowledged the findings.	{0 810}		

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{0 810}	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	{0 810}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences,	{01370}		

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{01370}	Continued From page 13 cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further action required.	{01370}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: No further action required.	{01380}		

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{01470}	Continued From page 14	{01470}		
{01470} SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any	{01470}		

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{01470}	Continued From page 15 training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required.	{01470}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the	{01910}		

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{01910}	Continued From page 16 resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action required.	{01910}		

Electronically Delivered

August 4, 2022

Administrator
Royal Age Assisted Living LLC
7047 Goodview Avenue South
Cottage Grove, MN 55016

RE: Project Number SL36630015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 20, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

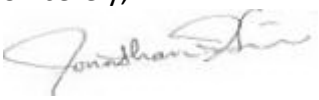
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.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

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

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

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

Sincerely,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-592-5119 Fax: 651-215-9697

HHH

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36630015 On July 19, 2022, through July 20, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five (5) residents, all of whom receive services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at	0 470		

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0 470	Continued From page 1 least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all five residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 470		

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0 470	Continued From page 2 has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 20, 2022, at 11:10 a.m., owner (O)-A confirmed the licensee had not developed or implemented a staffing plan. O-A stated the licensee had few clients and staff, and are able to cover the shifts as needed. The licensee lacked a policy on development of a staffing plan for assisted living facilities. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

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0 480	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents in the Assisted Living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated July 20, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for	0 490		

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0 490	Continued From page 4 providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure it offered or provided a daily program of social and recreational activities for all five residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a daily program of activities as required. On July 19, 2022, at 9:50 a.m., during a tour of	0 490		

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0 490	Continued From page 5 the facility, the surveyor observed the main entrance area and noted the lack of a daily activity schedule posted. On July 20, 2022, at 11:10 a.m., owner (O)-A stated the licensee provides activities and outings for the residents, but verified an activity schedule was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near	0 640		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL AGE ASSISTED LIVING LLC	7047 GOODVIEW AVENUE SOUTH COTTAGE GROVE, MN 55016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 640	Continued From page 6 telephones provided by the assisted living facility. This had the potential to affect all five residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the 911 emergency number in common areas of the assisted living. In addition, there was no evidence of the contact information or reporting number for the Minnesota Adult Abuse Reporting Center (MAARC). On July 19, 2022, during a facility tour at 9:50 a.m., observations of the facility's common areas were found to lack the required posting of the emergency number and information on reporting suspected maltreatment to MAARC. On July 20, 2022, at 11:10 a.m., owner (O)-A verified the required information was not posted in the common areas of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 650	Continued From page 7	0 650		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained a job description and training and competency testing in medication administration	0 650		

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0 650	Continued From page 8 for one of one unlicensed personnel (ULP)-B with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a start date of September 8, 2014, and provided cares and medication administration to licensee residents. ULP-B's record lacked documentation of a job description and training and competency testing in medication administration. On July 20, 2022, at 11:10 a.m., owner (O)-A stated ULP-B was trained and competency tested by the registered nurse in medication administration upon hire, but stated she was unable to find documentation of the training and competency testing. O-A also comfirmed ULP-B's record lacked a job description. The licensee's undated Unlicensed Personnel (ULP) Initial Training policy verified "documentation of completion of orientation requirements must be retained in the staff personnel file." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 650		

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0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the required interconnection and the minimum number of smoke alarms in the home. This has the potential to directly affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 780		

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0 780	Continued From page 10 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 20, 2022, approximately from 1:30 p.m. to 3:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-B. During the facility tour, survey staff observed the following findings: MISSING SMOKE ALARMS 1) Both hallways outside within the vicinity of the first level resident rooms #5 (near entrance) and #6 (behind the kitchen) were not provided with required smoke alarms. The LALD-B verified the findings and asked for guidance on the locations for installation. 2) The first level resident room # 5 (next to the entrance door) did not have a required smoke alarm inside the room. The LALD-B confirmed the finding and stated that the resident had moved out and the room currently was being used for storage and remodeling. INTERCONNECTION OF SMOKE ALARMS The testing of smoke alarms failed to sound all smoke alarms in the home as required for the interconnection of all smoke alarms. The finding was evident when the smoke alarms in resident rooms located on the upper-level floor, # 1, #2, #3, and #4 were tested, and each sounded local. Survey staff explained to the LALD-B that all required smoke alarms including the missing alarms identified at the above locations and the unfinished basement must be interconnected such that when any smoke alarm is activated, all smoke alarms sound in the home for notification.	0 780		

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0 780	Continued From page 11 On July 20, 2022, at approximately 4:00 p.m. during the exit interview, the survey staff explained the findings to the LALD-B. The LALD-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 790		

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0 790	Continued From page 12 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 20, 2022, approximately from 1:30 p.m. to 3:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-B. During the tour, survey staff observed the following findings: MINIMUM SIZE REQUIRED The mounted portable fire extinguisher unit on the second level floor did not meet the required minimum size rated type, 2-A:10-B:C. Survey staff reviewed the label on the unit on the second level hallway with a size rated type, 1-A:10-B:C. The finding was verified with the LALD-B as he asked about the rated type on the labels. He also asked about using a unit sitting nearby on the corner of the floor. Survey staff explained to the LALD-B that he may not use the unit sitting on the floor since the unit needed to be serviced by a vendor as the needle was observed to be located in the "empty" range of the gage and the unit was also missing the pin. MOUNTING HEIGHT The portable fire extinguisher located in the upper-level hallway was incorrectly mounted with the top height at 75 inches above the floor. The maximum height allowed by the state fire code for extinguishers weighing less than 40 pounds at 60 inches (5 feet) above the floor. MAINTENANCE/INSPECTIONS All portable extinguishers were observed with no	0 790		

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0 790	Continued From page 13 tags attached to indicate the required annual service and monthly inspections from this year, or any previous years. On July 20, 2022, at approximately 4:00 p.m. during the exit interview, the survey staff explained the above findings to the LALD-B. The LALD-B acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 800		

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0 800	Continued From page 14 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings are: On July 20, 2022, approximately from 1:30 p.m. to 3:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-B. During the tour, survey staff observed the following: 1) Survey staff asked the LALD-B to open the double-hung windows for the vacant first-level resident room # 5 (next to the entrance door) to measure the clear window openings. The windows opened at a maximum height of 4 inches with a width of 20 inches and did not open fully to provide a clear opening area of at least 20 inches in height due to screws installed on each side of the windows. Survey staff explained to LALD-B that the window openings for this room did not meet the minimum size egress window opening required for safe egress, and at least one window in the bedroom must meet the state standard minimum existing window opening size of at least 20 inches in height and a minimum with of 20 inches with a total of at least 648 square inches (4.5 square feet) required for egress window openings for bedrooms. The LALD-B commented that the screws were installed on the windows because they had incidents of elopement with the previous resident. 2) The sink drain inside the bathroom located on the second floor was clogged. Survey staff observed the water back up into the bowl while draining very slowly. The LALD-B commented that the resident tends to shave their beard into	0 800		

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0 800	Continued From page 15 the bowl and the drain needed to be clean-out again. 3) The main entrance door failed to allow for ready operation from the inside to exit the home immediately for safe egress during a fire or an emergency. The hardware installed on the door were (a) a door handle with an integral padlock and (b) two additional security guard hardware, with one constructed with an integral sliding lock located at 76 inches above the floor. Survey staff explained to the LALD-B that the main entrance door is an exit door and must be readily operable from the inside without special knowledge or effort. The installation of multiple security guards restricted quick operation, and the door operation would require special knowledge to exit the home for safe egress during a fire or an emergency. The LALD-B agreed not to use the top security guard with the lock. Survey staff asked the LALD-B to review with the local or state fire code official for proper use of security guards and/or additional security hardware (Minnesota State Fire Code sections 1010.1.9 and 1010.1.9.4). 4) The windows in resident rooms #1, #2, #3, and #5 were missing screens to prevent unwanted insects and added protection for residents. 5) The exhaust fan cover in the bathroom of resident room #1 was layered with thick dust and debris. 6) In the unfinished basement, a sanitary sump was observed without a cover, and standing water around the sump area. The LALD-B explained that he recently performed some repairs and the sump serves the laundry tub from the first floor. Survey staff explained to the LALD-B that the sump is part of a sanitary system	0 800		

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0 800	Continued From page 16 and must be covered with a secured gastight cover and floor areas must be maintained and kept dry to prevent mold growth. 7) The water heater in the unfinished basement was missing a discharge pipe from the pressure relief valve. 8) The egress window in resident room # 4 of the second floor had a reclining chair and a small refrigerator with other items obstructing the egress window for immediate access in case of fire and emergency. 8) The dishwasher was disconnected for repair and/or replacement work. All plumbing work must be permitted and performed by a licensed plumbing contractor. 9) The first-level bathroom sliding door was loose and not secured to the base. This posed a safety concern to the residents and employees. On July 20, 2022, at approximately 4:00 p.m. during the exit interview, the survey staff explained the above findings to the LALD-B. The LALD-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 17 (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the required fire safety and evacuation plan, the required training on fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors.	0 810		

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0 810	Continued From page 18 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 20, 2022, at approximately 3:30 p.m., survey staff asked and received from the LALD-B for the home's fire safety and evacuation documentation, the evacuation drill, and the training documentation for review. FIRE SAFETY AND EVACUATION PLAN The plan documentation lacked fire protection procedures for residents. TRAINING Documentation review showed the licensee lacked record of employee training on the fire safety and evacuation plan for the home. The minimum required employee training is upon hire and twice a year for fire safety and evacuation plan. Survey staff explained that the fire safety and evacuation training was in addition to the annual required emergency preparedness plan training. EVACUATION DRILLS The documentation review indicated the lack of fire and evacuation drills performed as required by the facility policy dated August 1, 2021, and Minnesota Statutes for assisted living. Record review showed employee fire drills performed to date were, June 17, 2022, March 2, 2022, and	0 810		

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0 810	Continued From page 19 September 2, 2021, with no time recorded for the drills. On July 20, 2022, at approximately 4:00 p.m. during the exit interview, the survey staff explained the above findings to the LALD-B. The LALD-B acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders;	01370		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
01370	Continued From page 20 (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations for the required topics for one of one unlicensed personnel (ULP-B) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a start date of September 8, 2014, and provided cares and medication administration to licensee residents.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36630	A. BUILDING: _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL AGE ASSISTED LIVING LLC	7047 GOODVIEW AVENUE SOUTH COTTAGE GROVE, MN 55016

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01370	Continued From page 21 ULP-B's employee record lacked evidence to indicate ULP-B completed training and/or practical skills evaluations as required in the following areas: -maintenance of a clean and safe environment -reports in change of the resident's condition to the supervisor designated by the facility -documentation requirements for all services provided and competency testing in the following areas: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -standby assistance techniques and how to perform them On July 20, 2022, at 11:10 a.m., owner (O)-A stated ULP-B was trained and competency tested by the registered nurse (RN) upon hire. owner O-A stated she would ensure all required areas of training and competency testing are completed by ULP-B. The licensee's undated Unlicensed Personnel (ULP) Initial Training policy included "documentation of completing of orientation requirements must be retained in the staff personnel [employee] file." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380		

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01380	Continued From page 22 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations for the required topics for one of one unlicensed personnel (ULP-B) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a start date of September 8, 2014,	01380		

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01380	Continued From page 23 and provided cares and medication administration to licensee residents. ULP-B's employee record lacked evidence to indicate ULP-B completed training and/or practical skills evaluations as required in the following areas: -observing, reporting, and documenting resident status and competency testing in the following areas: -reading and recording temperature, pulse, and respirations of the resident. On July 20, 2022, at 11:10 a.m., owner (O)-A stated ULP-B was trained and competency tested by the registered nurse (RN) upon hire. O-A stated she would ensure all required areas of training and competency testing are completed by ULP-B. The licensee's undated Unlicensed Personnel (ULP) Initial Training policy included "documentation of completing of orientation requirements must be retained in the staff personnel file." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's	01470		

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01470	Continued From page 24 policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	01470		

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01470	Continued From page 25 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for one of one unlicensed personnel ((ULP)-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a start date of September 8, 2014, and provided cares and medication administration to licensee residents. ULP-B's employee records lacked the following required orientation content: -the principles of person-centered planning and	01470		

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01470	Continued From page 26 service delivery and how they apply to direct support services provided by the staff person. On July 20, 2022, at 11:10 a.m., owner (O)-A stated she would ensure ULP-B and all licensee employees completed the above training and include the training in the employee records. The licensee's undated Unlicensed Personnel (ULP) Initial Training policy indicated the orientation will include the following topic: -"the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of one medication refrigerators. 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	01880		

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01880	Continued From page 27	01880		

resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On July 20, 2022, at 8:10 a.m., the licensee's medication refrigerator was observed with owner (O)-A. O-A confirmed the licensee employees monitor the refrigerator temperature daily, and ensure the temperature is maintained between 39-41 degrees farenheight. O-A verified no temperature log was maintained by the licensee employees.

The refrigerator contained:
- two Novolog (short acting insulin) pens
-one bottle of Gabapentin (anticonvulsant) liquid 250/milligrams (mg)/5 milliliters (ml).

The manufacturer's instructions for Novolog dated June 2021, indicated before opening store the insulin pens in the refrigerator (36-46 degrees Fahrenheit/F). Do not allow the Novolog to freeze.

The manufacturer's instructions for Gabapentin liquid, dated May 2022, indicated to store liquid medication in the refrigerator. Do not allow the Gabapentin liquid to freeze.

On July 20, 2022, at 11:10 a.m., O-A confirmed the licensee employees monitor the refrigerator temperature daily, and ensure the temperature is maintained between 39-41 degrees farenheight. O-A verified no temperature log was completed by the licensee employees.

The licensee's undated Medication Management

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01880	Continued From page 28 Policy verified "all medications will be stored in an area that has proper control of sanitation, light, temperature and humidity." No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01880		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication for one of one resident (R2) with record reviewed.	01910		

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01910	Continued From page 29 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked documentation of the disposition of medications to include the following required content: the medication's name, strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition. R2 was discharged on April 10, 2022. R2's prescriber orders dated April 8, 2022 , included two anti-anxiety medications, one antihistamine, and one anti-depressant. R2's Health Discharge Summary dated April 10, 2022, indicated all medications had been sent with the resident. On July 20, 2022, at 11:10 a.m., owner (O)-A stated she was unable to locate the disposition of medications for R2, but stated it was completed and should have been in the resident record. The licensee's undated Medication Management Policy indicated "when the resident is deceased, or services are terminated, all current medications may be given to the resident's	01910		

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01910	Continued From page 30 representative for disposal." The policy lacked the above disposition requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

Type: Full
Date: *07/20/22*
Time: 10:00:00
Report: 1013221202

Food and Beverage Establishment Inspection Report

Location:
Royal Age Assisted Living Llc
7047 Goodview Avenue South
Cottage Grove, MN55016
Washington County, 82

Establishment Info:
ID #: 0039238
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514580343
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(2) ** Priority 1 **

MN Rule 4626.0235A(2) Separate types of raw animal foods from other raw animal foods during storage, preparation and display based on cook temperature.

PACKAGE OF RAW HAMBURGER PATTIES WAS STORED DIRECTLY ON TOP OF AN OPEN PACKAGE OF RAW CHICKEN LOCATED IN THE KITCHEN FREEZER. COMPLY WITH ABOVE RULE. STAFF SEPARATED THE RAW MEAT BY FINAL COOK TEMPERATURE.

Comply By: 07/20/22

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

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

COLD TCS FOOD MEASURED ABOVE 41F LOCATED IN THE KITCHEN REFRIGERATOR. SEE TEMP LOG. COMPLY WITH ABOVE RULE. PER STAFF A NEW REFRIGERATOR WAS PURCHASED. TCS FOOD WAS DISCARDED AND REQUESTED STAFF MONITOR FOOD HOLDING TEMPERATURES.

Comply By: 07/20/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

FACILITY'S DISH MACHINE USES HOT WATER TO SANITIZE WARE. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH ABOVE RULE.

Comply By: 07/27/22

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.

CHLORINE SANITIZER IS USED WHEN MANUALLY WARE WASHING. NO CHLORINE TEST KIT WAS AVAILABLE. COMPLY WITH ABOVE RULE.

Comply By: 07/27/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO MN CFPM WAS EMPLOYED AT THE FACILITY. THE OPERATOR HAD A CURRENT FOOD MANAGERS COURSE CERTIFICATE. COMPLY WITH ABOVE RULE. THE MN CFPM INFORMATION WAS PROVIDED.

Comply By: 10/17/22

4-600 Cleaning Equipment and Utensils

4-602.13

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.

GRIME AND BUILD UP WERE ON THE CABINET HANDLES AND DOORS LOCATED IN THE KITCHEN. CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 07/20/22

4-900 Protecting Clean Items

4-903.11A

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

2 PLASTIC CONTAINERS WITH FOOD DEBRIS INSIDE WERE STORED WITH CLEAN WARE IN THE KITCHEN. STAFF IDENTIFIED THE CONTAINERS AS BELONGING TO EMPLOYEES. COMPLY WITH ABOVE RULE. THE ITEMS WERE REMOVED.

Corrected on Site

Food and Equipment Temperatures

Process/Item: Butter
Temperature: 47 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Cheese
Temperature: 51 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Yogurt
Temperature: 50 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Type: Full
Date: *07/20/22*
Time: 10:00:00
Report: 1013221202
Royal Age Assisted Living Llc

Food and Beverage Establishment Inspection Report

Process/Item: Chicken
Temperature: 25 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator J. Bertelsen.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, granite counter tops, wood floor, and a popcorn textured ceiling. The kitchen finishes and surfaces were well maintained. When updated the ceiling and floor need to be smooth, durable, easily cleanable, and nonabsorbent.

A 2 basin sink is located in the kitchen. One basin must be designated for hand washing.

A residential dish machine is located in the kitchen. The sanitize and high temp cycles are used for washing ware.

MN CFPM information: https://www.health.state.mn.us/communities/environment/food/cfpm/index.html

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, date marking, cleaning, serving highly susceptible populations, and food handling procedures.

Food safety guidance documents were emailed.

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 1013221202 of 07/20/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Mthunzi Dewa
Operator

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