DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 31, 2022

Administrator
Knutson Place Apartments
801 Luther Place
Albert Lea, MN 56007

RE: Project Number(s) SL30310015

Dear Administrator:

On August 24, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on June 16, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the June 16, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on June 16, 2022, found not corrected at the time of the August 24, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - $500.00

The details of the violations noted at the time of this follow-up evaluation completed on August 24, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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 Jodi Johnson, Supervisor, at 507-344-2730 .

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,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30310	A. BUILDING: _____ B. WING _____	R 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNUTSON PLACE APARTMENTS	801 LUTHER PLACE ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL30310015 On August 18, 2022, August 19, 2022, August 23, 2022, and August 24, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on June 16, 2022. At the time of the survey, there were 43 residents: 15 of which were receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}		
{0 110} SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.	{0 110}		

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{0 110}	Continued From page 1 This MN Requirement is not met as evidenced by: No further action required.	{0 110}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (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	{0 470}		

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{0 470}	Continued From page 2 licensee failed to ensure that one or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents, were 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. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee held an assisted living facility license with a bed capacity of 48 residents; current census was 43 residents. During the initial survey's entrance conference on June 13, 2022, at 10:15 a.m. registered nurse/licensed assisted living director (RN/LALD)-A stated beside nursing coverage during the day Monday through Friday, there was typically one unlicensed personnel (ULP) from 7:00 a.m. to 3:00 p.m. and one ULP from either 2:00 p.m. or 3:00 p.m. to 8:00 p.m. each day. RN/LALD-A stated between the hours of 8:00 p.m. to 7:00 a.m. staff from the attached nursing home responded. During the initial survey on June 14, 2022, at approximately 11:30 a.m. licensed practical nurse (LPN)-C reviewed the Emergency Call Report form with surveyor dated December 16, 2021, to	{0 470}		

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{0 470}	Continued From page 3 June 14, 2022. LPN-C identified call cords answered by nursing home staff as times were not noted. The following dates were identified: December 20, 2021, January 18, 2022, February 10, 2022, March 6, 2022, April 4, 2022, May 7, 2022, May 21, 2022, June 14, 2022. During the initial survey on June 14, 2022, at 11:55 a.m. RN/LALD-A stated the licensee did not have a waiver for using nursing home staff between the hours of 8:00 p.m. and 7:00 a.m. and if a pull cord was utilized by a resident during this time, a staff member from the attached nursing home would come to assist as the call light system was integrated. RN/LALD-A further stated there was a protocol for the nursing home staff to follow if a resident fell or 911 needed to be called. RN/LALD-A further started nursing home staff were trained on the emergency preparedness to assist the licensee's residents. During the initial survey on June 14, 2022, at 11:57 a.m. human resource director (HR)-E stated nursing home staff that cover between the hours of 8:00 p.m. to 7:00 a.m. were not trained on assisted living standards. HR-E indicated all staff were hired under the company umbrella, not site specific. On the licensee's Statement of Deficiencies and Plan of Correction dated June 16, 2022, under the column for the provider's plan of correction was the following statements: - A variance request was submitted to the State of Minnesota with our current staffing plan (after hours policy including staff from the skilled nursing area). We are waiting on a decision by the committee. - [The licensee] has established an Emergency Call Protocol for staff after hours to respond to	{0 470}		

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{0 470}	Continued From page 4 the calls of tenants at [the facility] from the hours of 8pm-7am. - This protocol instructs nursing assistants on what to do in the case of an emergency. The protocol lists scenario and how to respond appropriately. - A waiver request in sent to MDH requesting the approval of skilled nursing staff to assist with pendant calls after the hours of 8pm and prior to 7am." This had a documented completion date of July 7, 2022. On August 22, 2022, at 2:06 p.m. RN/LALD-A, stated in an e-mail, "in the list of corrections, it states that we are using the staff at the skilled nursing area and waiting for approval of our variance request. We do not have a night shift. Prior to getting our license in 8/2021, we did not have staff after 8pm. I filled out a variance request to continue to use the staff in the skilled area. I am waiting for approval." The licensee's Emergency Call Protocol undated, identified residents must be 90% independent in order to maintain residency. The document identified between the hours of 8:00 p.m. - 7:00 a.m. the licensee would incorporate the assistance of nursing aides from the skilled care department as staffing was tight related to COVID-19. A calling tree was developed to include common situations to make the decision-making process easier for when to call 911 and/or the on-call nurse. The document also included: -in the situation that a tenant is injured requiring more than basic first aid (Band-Aid to small scratch or cut) an ambulance should be called; -If a tenant falls and needs a lift assistance your radio should be used to call the nurse at skilled	{0 470}		

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{0 470}	Continued From page 5 care department to explain the situation. If no other staff are available to assist the emergency services should be called; -A nurse should be at the skilled care department at all times. If two nurses are present during the evening, then lift assistance can be provided. If only one nurse is scheduled emergency service should be contacted for lift assistance. The licensee's Direct-Care Staffing Plan dated November 20, 2021, identified between the hours of 10:00 p.m. and 6:00 a.m. there would be direct-care staff able to respond to a resident's request for assistance with health and safety needs within a reasonable amount of time. These staff would be located in an attached building in order to respond within a reasonable amount of time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) 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	{0 480}		

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{0 480}	Continued From page 6 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}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 510}		
{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	{0 640}		

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{0 640}	Continued From page 7 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}		
{0 780} 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;	{0 780}		

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{0 780}	Continued From page 8 This MN Requirement is not met as evidenced by: No further action required.	{0 780}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and 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	{0 810}		

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{0 810}	Continued From page 9 drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01290} SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: No further action required.	{01290}		
{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;	{01370}		

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{01370}	Continued From page 10 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further action required.	{01370}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	{01380}		

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{01380}	Continued From page 11 (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}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	{01620}		

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{01620}	Continued From page 12 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.	{01640}		

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	30310	A. BUILDING: _____ B. WING _____	R 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01640}	Continued From page 13 (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: No further action required.	{01640}		
{01770} SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: No further action required.	{01770}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	{01940}		

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{01940}	Continued From page 14 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action required.	{01940}		
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{03090}		

Electronically Delivered

July 25, 2022

Administrator
Knutson Place Apartments
801 Luther Place
Albert Lea, MN 56007

RE: Project Number(s) SL30310015

Dear Administrator:

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

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

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

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

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

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

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

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

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

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

Sincerely,

Jodi Johnson, Supervisor
State Rapid Response Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 507-344-2730 Fax: 651-281-9796

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30310	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNUTSON PLACE APARTMENTS	801 LUTHER PLACE ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30310015 On June13, 2022, through June 16, 2022, the Minnesota Department of Health conducted a survey at the above provider and the following correction orders are issued. At the time of the survey, there were 44 residents; 17 receiving 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 issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure registered nurse/licensed assisted living director (RN/LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 13, 2022, at 8:22 a.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated RN/LALD-A currently held a LALD license effective through October 31, 2022; however, RN/LALD-A's license lacked an organization listed as the Director of Record for the licensee. On June 13, 2022, at 12:00 p.m. RN/LALD-A acknowledged they were not listed as Director of Record with BELTSS and stated they were not aware they needed to be registered as Director of Record for licensee.	0 110		

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0 110	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (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	0 470		

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0 470	Continued From page 3 licensee failed to ensure that one or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents, were 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. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee held an assisted living facility license with a bed capacity of 48 residents; current census was 44 residents. During the entrance conference on June 13, 2022, at 10:15 a.m. registered nurse/licensed assisted living director (RN/LALD)-A stated beside nursing coverage during the day Monday through Friday, there was typically one unlicensed personnel (ULP) from 7:00 a.m. to 3:00 p.m. and one ULP from either 2:00 p.m. or 3:00 p.m. to 8:00 p.m. each day. RN/LALD-A stated between the hours of 8:00 p.m. to 7:00 a.m. staff from the attached nursing home responded. On June 14, 2022, at approximately 11:30 a.m. licensed practical nurse (LPN)-C reviewed the Emergency Call Report form with surveyor dated December 16, 2021, to June 14, 2022. LPN-C identified call cords answered by nursing home	0 470		

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0 470	Continued From page 4 staff as times were not noted. The following dates were identified: December 20, 2021, January 18, 2022, February 10, 2022, March 6, 2022, April 4, 2022, May 7, 2022, May 21, 2022, June 14, 2022. On June 14, 2022, at 11:55 a.m. RN/LALD-A stated the licensee did not have a waiver for using nursing home staff between the hours of 8:00 p.m. and 7:00 a.m. and if a pull cord was utilized by a resident during this time, a staff member from the attached nursing home would come to assist as the call light system was integrated. RN/LALD-A further stated there was protocol for the nursing home staff to follow if a resident fell or 911 needed to be called. RN/LALD further started nursing home staff were trained on the emergency preparedness to assist the licensee's residents. On June 14, 2022, at 11:57 a.m. human resource director (HR)-E stated nursing home staff that cover between the hours of 8:00 p.m. to 7:00 a.m. were not trained on assisted living standards. HR-E indicated all staff are hired under the company umbrella, not site specific. The licensee's Emergency Call Protocol undated, identified residents must be 90% independent in order to maintain residency. The document identified between the hours of 8:00 p.m. - 7:00 a.m. the licensee would incorporate the assistance of nursing aids from the skilled care department as staffing was tight related to COVID-19. A calling tree was developed to include common situations to make the decision-making process easier for when to call 911 and or the on-call nurse. The document also included: -in the situation that a tenant is injured requiring	0 470		

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0 470	Continued From page 5 more than basic first aid (Band-Aid to small scratch or cut) an ambulance should be called; -If a tenant falls and needs a lift assistance your radio should be used to call the nurse at skilled care department to explain the situation. If no other staff are available to assist the emergency services should be called; -A nurse should be at the skilled care department at all times. If two nurses are present during the evening, then lift assistance can be provided. If only one nurse is scheduled emergency service should be contacted for lift assistance. The licensee's Direct-Care Staffing Plan dated November 20, 2021, identified between the hours of 10:00 p.m. and 6:00 a.m. there would be direct-care staff able to respond to a resident's request for assistance with health and safety needs within a reasonable amount of time. These staff would be located in an attached building in order to respond within a reasonable amount of time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) 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)	0 480		

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0 480	Continued From page 6 guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 13, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 7 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This deficient practice had the potential to affect all the licensee's current 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 all staff, residents, and visitors.) The findings include: The licensee failed to ensure employees in direct contact with residents were wearing appropriate personal protective equipment (PPE) as per the Centers for Disease Controls (CDC) and Minnesota Department of Health (MDH)	0 510		

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0 510	Continued From page 8 guidelines. The Minnesota Department of Health (MDH) document dated April 7, 2022, titled COVID-19 PPE and Source Control Grids for Congregate Care Settings by Community Transmission Level reads: "PPE grid for health care workers, direct service providers (i.e. includes employees, contractors, volunteers, etc.); when community transmission levels are high or substantial, those working with residents without suspected or confirmed SARS-CoV-2 infection should wear a face mask (source control) and eye protection. The Centers for Disease Control (CDC) Integrated County View Data Tracker for COVID-19 listed the COVID-19 community transmission rate as "high" for Freeborn County at the time of the survey. On June 13, 2022, at 11:20 a.m. during the facility tour, registered nurse/licensed assisted living director (RN/LALD)-A and the surveyor walked through a sitting area by the nursing office where residents were gathered, walked through the dining room where residents were eating, and met and spoke to residents in the hallway coming back from lunch. RN/LALD-A wore a surgical face mask, but lacked eye protection. On June 14, 2022, at 7:49 a.m. unlicensed personnel (ULP)-B was observed with R3. ULP-B administered medications, completed his COVID screen, and applied compression wraps on both legs for R3. ULP-B wore a surgical face mask, but lacked eye protection. On June 14, 2022, at 10:35 a.m. housekeeper (H)-D was observed to speak to R4 and R2 sitting in the hallway, then knocked and greeted R5	0 510		

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	30310	A. BUILDING: _____ B. WING _____	06/16/2022

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0 510	Continued From page 9 while entering her room. H-D wore a N-95 style mask, but lacked eye protection. On June 14, 2022, at 2:08 p.m. RN/LALD-A stated eye protection must be worn when assisting the residents with cares such as shower/bathing, medication administration, compression wraps, or anytime you were within six feet of a resident. RN/LALD added staff should have eye protection on "all the time" when in residential areas, which included the hallways. RN/LALD-A further stated she was aware Freeborn County was listed as "high" for community transmission rate on the CDC Integrated County View Data Tracker for COVID-19. RN/LALD-A stated she was aware staff had not been wearing eye protection indicating she had been having a hard time enforcing it. The licensee's Standard Precautions policy dated September 10, 2020, indicated standard precautions would be used for all patient care based on a risk assessment that would protect healthcare providers from infection and prevent the spread of infection from patient to patient. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	0 510		
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	0 640		

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0 640	Continued From page 10 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 911 emergency number as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 13, 2022, at 11:35 a.m. the facility was observed to be lacking posting of the MAARC hotline in the common areas of the facility. Registered nurse/licensed assisted living director (RN/LALD)-A confirmed this finding and indicated she was not aware it had been missing. No further information was provided.	0 640		

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0 640	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all	0 680		

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0 680	Continued From page 12 current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 16, 2022, at 1:00 p.m. the surveyor reviewed the emergency preparedness plan and Appendix Z with registered nurse/licensed assisted living director (RN/LALD)-A. The licensee's EP plan consisted of several documents and policies, undated. The plan included a hazard and vulnerability assessment and various policies/procedures. The licensee's plan lacked the following required content: - Maintain emergency preparedness plan and update annually; - EP program patient population; - Subsistence needs for staff and residents during emergency situation; - Procedures for tracking staff and residents; - Policy and procedures regarding use of volunteers; - Policy and procedure to address the development of arrangements with other facilities to receive residents in the event of limitations/cessation of operations to maintain the continuity of services with signed agreements and a plan to transport in an evacuation; - Policy and procedure to address providing care	0 680		

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0 680	Continued From page 13 and treatment at alternate care sites under the 1135 waiver; - Emergency Officials Contact Information -The State Licensing and Certification Agency -The Minnesota Office of Ombudsman for Long-Term Care - Development of a communication plan, including: -primary and alternate means for communication; - Sharing Information on Occupancy/Needs On June 16, 2022, at 1:00 p.m. RN/LALD-A confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z to include the above requirements. RN/LALD-A indicated the attached nursing home had an emergency preparedness plan, but it was not customized to the assisted living and that was something she could work on. The licensee's Plans for Emergencies and Natural Disasters policy dated July 10, 2021, indicated the licensee would have a written plan of action to facilitate care and services in response to a natural disaster or another type of emergency that may affect the licensee's ability to provide services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 780		

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0 780	Continued From page 14 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain smoke alarms in the facility and ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 780		

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0 780	Continued From page 15 has affected or has the potential to affect a large portion or all residents). The findings include: On June 15, 2022, between 9:00 a.m. to 1:00 p.m. survey staff observed the facility had two apartment styles: studio style apartment with no separation from common area and sleeping area, and one bedroom apartment with a bedroom separate from the common area. Studio apartments did not have a smoke alarm and one bedroom apartments did not have interconnected smoke alarms in the common area and bedroom. Director of maintenance (DM)-F and registered nurse/licensed assisted living director (RN/LALD)-A verbally confirmed survey staff observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping 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	0 810		

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0 810	Continued From page 16 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).	0 810		

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0 810	Continued From page 17 Findings include: On June 15, 2022, between 9:00 a.m. to 1:00 p.m., survey review of documentation showed the following: 1. No map or floorplan was provided identifying and number of resident rooms 2. No records were provided to confirm that procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation exist 3. No records were provided to confirm that the staff of the facility had received initial fire safety and evacuation training at the time of hire, as well as ongoing required twice per year thereafter. 4. No records were provided to confirm that residents capable of assisting in their own evacuation are being trained on proper actions at least annually. 5. No records were provided to confirm that evacuation drills are being conducted twice per year per shift with at least one drill every other month Director of maintenance (DM)-F and registered nurse/licensed assisted living director (RN/LALD)-A verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01290	Continued From page 18	01290		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for staff assisting in cares from the attached nursing home of licensee and for one of two employees (licensed practical nurse (LPN)-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01290		

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01290	Continued From page 19 The findings include: LPN-C was hired on October 28, 2013, and started providing direct care and services to the licensee's residents under the assisted living license on August 1, 2021. LPN-C's employee record contained a background study dated November 1, 2013, for a separate location operated by the licensee's owner. LPN-C's employee record lacked evidence the licensee affiliated a background study for their license. On June 14, 2022, at 11:57 a.m. human resource director (HR)-E confirmed staff assisting with cares between the hours of 8:00 p.m. and 7:00 a.m. from the attached nursing home did not have background studies that were affiliated, but rather under a different license for the nursing home. On June 15, 2022, at 2:25 p.m. HR-E confirmed LPN-C's background study was submitted under a different license and had not been affiliated. HR-E stated she had affiliated the manager, but did not do all the current employees hired prior to August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all	01370		

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01370	Continued From page 20 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, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	01370		

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01370	Continued From page 21 Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care 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's employee record lacked evidence to indicate the employee completed training and/or practical skills evaluations as required 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; - medication, exercise, and treatment reminders; - communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; and - awareness of commonly used health technology equipment and assistive devices. ULP-B started employment and began providing assisted living services on May 10, 2022.	01370		

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01370	Continued From page 22 On June 14, 2022, at 7:49 a.m. ULP-B was observed to administer medications, completed a COVID screen, and applied compression ACE wraps to both legs for R3. ULP-B's employee record contained a transcript which listed various training topics; however, the transcript lacked evidence of the above required topics. On June 16, 2022, at 12:10 p.m. registered nurse/licensed assisted living director (RN/LALD)-A indicated she was sure a nurse had completed some of these with ULP-B, but was unable to locate any documentation. RN/LALD-A further stated she did not know training and competencies needed to be completed on all of the required topics, and verified the above topics were lacking from ULP-B's employee file. The licensee's Documentation of Staff Orientation and Training policy dated January 2020, noted to keep copies of dated certificates of training/competency for each module or competency that is successfully achieved. Maintain a summary of training/competencies (with dates) for each unlicensed person. The policy did not direct what training and competency evaluations must be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and	01380		

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01380	Continued From page 23 competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations contained all the required training prior to providing direct care 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's employee record lacked evidence to indicate the employee completed training and/or	01380		

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01380	Continued From page 24 practical skills evaluations as required in the following areas prior to providing direct care services: - reading and recording temperature, pulse, and respirations of the client; - recognizing physical, emotional, cognitive, and developmental needs of the client; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. ULP-B started employment and began providing assisted living services on May 10, 2022. On June 14, 2022, at 7:49 a.m. ULP-B was observed to administer medications, completed a COVID screen, and applied compression ACE wraps to both legs for R3. ULP-B's employee record contained a transcript which listed various training topics; however, the transcript lacked evidence of the above required topics. On June 16, 2022, at 12:10 p.m. registered nurse/licensed assisted living director (RN/LALD)-A indicated she was sure a nurse had completed some of these with ULP-B, but was unable to locate any documentation. RN/LALD-A further stated she did not know training and competencies needed to be completed on all the required topics, and verified the above topics were lacking from ULP-B's employee file. The licensee's Documentation of Staff Orientation and Training policy dated January 2020, noted to keep copies of dated certificates of training/competency for each module or competency that is successfully achieved.	01380		

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01380	Continued From page 25 Maintain a summary of training/competencies (with dates) for each unlicensed person. The policy did not direct what training and competency evaluations must be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=E	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	01470		

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01470	Continued From page 26 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 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff assisting in cares from the attached nursing home of licensee and one of two employees (licensed practical nurse (LPN)-C) received orientation to assisted living facility licensing requirements and regulations before providing services.	01470		

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01470	Continued From page 27 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: LPN-C was hired on October 28, 2013, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On June 15, 2022, at 9:00 a.m. LPN-C was observed setting up medications for residents in the hallway of 3rd floor. LPN-C's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470		

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01470	Continued From page 28 - 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 On June 14, 2022, at 11:57 a.m. human resource director (HR)-E stated nursing home staff that cover between the hours of 8:00 p.m. to 7:00 a.m. were not trained on assisted living orientation. HR-E indicated all staff are hired under the company umbrella, not site specific. On June 16, 2022, at 10:10 a.m. registered nurse/ licensed assisted living director (RN/LALD)-A verified LPN-C's record lacked the above required content. RN/LALD-A stated she had put together a packet in July 2021, to meet the requirement, but verified it was lacking the above noted requirements. New employees completed an Educare (online training system) module that meets the requirements now, but it was not assigned to staff hired prior to August 1, 2021, nor was it assigned to nursing home staff that cover during the hours of 8:00 p.m. - 7:00 a.m. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days	01620		

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01620	Continued From page 29 after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment for one of two residents (R3) 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).	01620		

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01620	Continued From page 30 The findings include: R3 admitted to services on April 23, 2020, with diagnoses including bipolar II (a mental health disorder), diabetes mellitus (a condition that affects the way the body processes blood glucose), mixed incontinence (combination of urge and stress involuntary loss of large or small amounts of urine), and depression (mental disorder with sadness and lack of interest in activities). R3's Service Plan dated March 22, 2022, indicated R3 received services including assistance with medication setup and administration. R3's last two assessments were requested. 90-day assessments dated December 31, 2021, and April 7, 2022, were provided. The April 7, 2022, assessment was 97 days after the previous assessment (seven days late). On June 15, 2022, at 11:45 a.m. registered nurse/licensed assisted living director (RN/LALD)-A verified R3's assessment had been completed late. RN/LALD-A indicated there had been a lot going on during this time for the licensee and the reassessment "was missed." The licensee's Nursing Assessment: Initial and On-Going of Clients Under the Comprehensive Licensed Agency policy dated July 10, 2021, noted the RN would determine the frequency of re-assessments based on the client's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment.	01620		

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01620	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two residents' (R2) service plans were developed and implemented with records reviewed.	01640		

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01640	Continued From page 32 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 evidence that a service plan had been developed. R2's diagnoses included diabetes mellitus (a condition that affects the way the body processes blood glucose), hypertension (high blood pressure), and atrial fibrillation (an irregular often fast heart rate). R2's Care Plan dated April 7, 2022, indicated the resident received services which included medication setup. On June 13, 2022, at 10:33 a.m. R2 stated a nurse set up his medications each week in a med box. On June 16, 2022, at 12:10 p.m. registered nurse/licensed assisted living director (RN/LALD)-A stated there was a lot going on when R2 moved in and verified R2 did not have a service plan developed and implemented as required. The licensee's Contents of Service Plans policy dated July 10, 2021, noted all residents would have an up-to-date service plan identifying services to be provided based on the assessment	01640		

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01640	Continued From page 33 by the RN and/or other licensed health professional. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R2 and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 13, 2022, at approximately 10:15 a.m., registered nurse/licensed assisted living director	01770		

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01770	Continued From page 34 (RN/LALD)-A confirmed the licensee provided medication management services to the licensee's residents, including medication setup. R2 R2 lacked a service plan. R2's Care Plan dated April 7, 2022, identified R2 needed the nurse to set up his medications. R2's prescriber orders dated April 18, 2022, included the following orders: Glucophage XR 500 milligrams (mg) by mouth twice daily (bid) for diabetes; Glucotrol XL 5 mg daily for diabetes; tamsulosin hydrochloride 0.4 mg daily for urinary retention; Lipitor 20 mg daily at bedtime for cholesterol; lisinopril 10 mg daily for high blood pressure; metoprolol tartrate 25 mg 1/2 tablet twice daily for blood pressure; Demadex 20 mg 2 tables daily for edema; acetaminophen 325 mg 2 tables four times a day for pain; aspirin 81 mg daily for heart health; coumadin 5 mg daily on Monday, Wednesday, and Friday for atrial fibrillation; coumadin 7.5 mg daily on Saturday, Sunday, Tuesday, and Thursdays for atrial fibrillation. Though R2's treatment record identified nurse would fill pill packs every Wednesday, R2's record lacked documentation by the licensed nurse at the time of setup to include the the name of medication, quantity of dose, times to be administered, and route of administration. R3 R3's Service Plan dated March 22, 2022, noted services including medication setup and administration. R3's Daily Care Plan dated September 3, 2021,	01770		

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01770	Continued From page 35 identified R3 had weekly pill pack fills by the nurse and medication administration twice daily by staff. R3's prescriber orders dated March 28, 2022, included the following orders: acetaminophen 500 mg 2 tables three times a day for pain; atorvastatin calcium 80 mg 1/2 tablet orally at night for cholesterol; dofetilide 250 micrograms twice daily for irregular heart beat; Eliquis 5 mg twice daily for atrial fibrillation; furosemide 40 mg 2 tablets orally twice a day for fluid retention; lisinopril 40 mg daily for blood pressure; loratadine 10 mg daily for allergies; melatonin 3 mg daily for sleep; tamsulosin hydrochloride 0.4 mg for urinary retention; calcium poycarbophil 625 mg daily for constipation; multivitamin daily for health supplement; metoprolol tartrate 100 mg twice daily for irregular heart beat; venlafaxine hydrochloride 75 mg daily for depression; Colace 100 mg twice daily for constipation; doxepin hydrochloride 25 mg daily at bedtime for sleep; Farxiga 5 mg daily for diabetes; and budesonide 3 mg 3 tablets by mouth daily for breathing. Though R3's treatment record identified nurse would fill pill packs every Wednesday. R3's record lacked documentation by the licensed nurse at the time of setup to include the the name of medication, quantity of dose, times to be administered, and route of administration. On June 14, 2022, at 11:15 a.m. licensed practical nurse (LPN)-C stated she only documented that a medication set up had been completed each week. LPN-C verified the documentation did not include what medications, quantity of dose, times, or route. LPN-C further stated this was the process used for all medication set ups.	01770		

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01770	Continued From page 36 On June 14, 2022, at 11:30 a.m. registered nurse/licensed assisted living director (RN/LALD)-A verified this was the licensee's process and it should be changed to match the statute. The licensee's Medication Administration System-Dosage Box Setup policy dated July 10, 2022, noted when the licensed nurse completed medication setup in the dosage boxes, the nurse would document each individual medication that had been set up on the medication administration record (MAR). No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30310	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNUTSON PLACE APARTMENTS	801 LUTHER PLACE ALBERT LEA, MN 56007

(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
01940	Continued From page 37 (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R3) with treatment 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: During the entrance conference on June 13, 2022, at 10:15 a.m. registered nurse/licensed assisted living director (RN/LALD)-A stated the licensee provided treatment management services to residents, including compression stockings and all cotton elastic (ACE) wraps.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30310	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNUTSON PLACE APARTMENTS	801 LUTHER PLACE ALBERT LEA, MN 56007

(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
01940	Continued From page 38 R3's Service Plan dated March 22, 2022, indicated R3 received services including medication administration and daily treatment management. On June 14, 2022, at 7:49 a.m. unlicensed personnel (ULP)-B was observed to administer medications, complete a COVID screen, and apply compression ACE wraps to both legs for R3. R3's prescriber orders dated March 28, 2022, included an order for light compression wraps on both legs; on in the a.m. and off in the p.m. R3's documented treatment record from May 15, 2022, to June 13, 2022, included light compression wraps on both legs; on in the a.m. and off in the p.m. R3's records lacked a treatment management plan to include the following required content: - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On June 16, 2022, at 10:51 a.m. RN/LALD-A stated the development of a treatment plan had	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30310	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNUTSON PLACE APARTMENTS	801 LUTHER PLACE ALBERT LEA, MN 56007

(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
01940	Continued From page 39 been missed. RN/LALD-A indicated originally R3's outside home care agency had completed the task, and the licensee did not acquire the task until the end of March 2022. RN/LALD-A further verified residents should have an individualized treatment plan and resident specific instructions to include when to notify a nurse for all treatments. The licensee's Development of the Individualized Treatment and Therapy Plan and Individualized Treatment Administration Record policy dated July 10, 2021, indicated following a nursing assessment, the RN develops an individualized treatment and therapy management plan for the client receiving management. For each client receiving treatment and therapy management of ordered or prescribed treatments or therapy services, the RN will develop an individualized plan that contains a written statement of the treatment or therapy services that will be provided to the client. The plan will contain at least the following: a. A statement of the type of services that will be provided; b. Documentation of specific client instructions relating to the treatments or therapy administration; c. Identification of treatment or therapy task that will be delegated to unlicensed personnel; d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services, and e. Any client-specific requirements relating to documentation of treatment or therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30310	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNUTSON PLACE APARTMENTS	801 LUTHER PLACE ALBERT LEA, MN 56007

(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
01940	Continued From page 40 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff and any visitors of the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include:	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30310	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNUTSON PLACE APARTMENTS	801 LUTHER PLACE ALBERT LEA, MN 56007

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03090	Continued From page 41 On June 13, 2022, at 10:00 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. On June 13, 2022, at 11:32 a.m. registered nurse/ licensed assisted living director (RN/LALD)-A stated the facility had a camera system, but it had not been working since April 2022. RN/LALD-A was not aware of the posting requirement. The licensee's Electronic Monitoring policy dated July 20, 2021, lacked direction on the posting requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Division of Envrionmental Health, FPLS
PO BOX 64975
St Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/13/22*
Time: 13:00:00
Report: 8040221008

Food and Beverage Establishment Inspection Report

Location:
Knutson Place Apartments
801 Luther Place
Albert Lea, MN56007
Freeborn County, 24

Establishment Info:
ID #: 0037471
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073738226
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision

2-102.11JKLMO ***** Priority 2 *****

MN Rule 4626.0030JKLMO The person in charge must be able to demonstrate their knowledge to the inspector of the food safety risks within their food operation and the relationship of the following factors to preventing foodborne disease: maintaining the food establishment and equipment in a clean condition and in good repair; procedures for cleaning and sanitizing utensils and food-contact surfaces of equipment; the importance of adequate food service equipment; responsibilities when a HACCP plan is required; proper use of toxic compounds in the establishment; and preventing contamination of the water supply from plumbing cross connections or backflow.

CERTIFIED FOOD PROTECTION MANAGER WAS NOT AWARE OF MAXIMUM REGISTERING TEMPERATURE DEVICE REQUIREMENT FOR HIGH TEMP DISH MACHINE. INSPECTOR LOCATED MAXIMUM REGISTERING TEMPERATURE DEVICE IN BASKET ABOVE PREP AREA.

Comply By: 06/13/22

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.

UNABLE TO LOCATE QUATERNARY AMMONIUM TEST STRIPS TO MEASURE SANITIZER CONCENTRATION.

Comply By: 06/27/22

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

DOMESTIC 3 WELL BUFFET SERVER OBSERVED IN DRY GOODS STORAGE. REMOVE NON-NSF APPROVED ITEM.

Comply By: 06/20/22

4-200 Equipment Design and Construction

4-201.11BMN

MN Rule 4626.0506B Provide an exhaust ventilation hood that meets the requirements in the Minnesota Mechanical Code, Minnesota Rules, chapter 1346.

DOUBLE COMBI-OVEN HAS BEEN MOVED AND IS NOT FULLY UNDER THE EXHAUST HOOD. MOVE OVEN BACK SO IT IS COMPLETELY UNDER THE EXHAUST HOOD.

Comply By: 06/20/22

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

MULTIPLE SINK FAUCETS LEAKING.

Comply By: 07/13/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

POST HANDWASHING SIGNAGE AT ALL KITCHEN HAND SINKS.

Comply By: 06/20/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

WET MOP HEAD OBSERVED IN MOP SINK.

Comply By: 06/14/22

Surface and Equipment Sanitizers

Hot Water: = at 165 Degrees Fahrenheit
Location: DISHMACHINE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *06/13/22*
Time: 13:00:00
Report: 8040221008
Knutson Place Apartments

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: BLUEBERRIES
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	2	5

INSPECTION CONDUCTED AS PART OF HRD SURVEY.

HRD TEAM LEAD SUSAN KALIS

DISCUSSED EMPLOYEE ILLNESS POLICY, FOOD PRODUCTION AND LIMITED USE OF KITCHEN WITH CERTIFIED FOOD PROTECTION MANAGER GWEN HERNANDEZ.

GWEN STATED THAT THIS KITCHEN PREPARES EGGS MADE TO ORDER EACH DAY AND PANCAKES ON MONDAYS. ALL OTHER FOODS ARE PREPARED IN THE ATTACHED NURSING HOME KITCHEN AND TRANSPORTED OVER TO THIS KITCHEN WHERE THE FOOD IS KEPT IN HOT WELLS PRIOR TO SERVICE.

ESTABLISHMENT SERVES PASTEURIZED EGGS.

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 8040221008 of 06/13/22.

Certified Food Protection Manager GWEN HERNANDEZ

Certification Number: FM92414 Expires: 01/20/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
GWEN HERNANDEZ
CFPM

Signed: _____
Matthew Finkenbiner
Sanitarian Supervisor
Rochester District Office
507-206-2744
matthew.finkenbiner@state.mn.us