Electronically Delivered

March 3, 2023

Licensee
Countryside Catered Senior Living
650 El Dorado Street
Owatonna, MN 55060

RE: Project Number(s) SL30584015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 2, 2023, 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.

LICENSING ORDERS
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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

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

Please address your cover letter for reconsideration requests to:

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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30584	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CATERED SENIOR LIV	650 EL DORADO STREET OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL30584015-0 On January 30, 2023, through February 2, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 60 active residents; 17 receiving services under the Assisted Living/ Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the	0 580		

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0 580	Continued From page 1 quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain documentation of quality management activity. This had the potential to affect 17 residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 30, 2023, at 2:45 p.m., a request was made to provide the licensee's quality management policy and documentation of quality management activity. Housing director (HD)-B provided a binder which included two forms entitled QAPI Action Plan, dated 2023, which included goals and objectives for "smooth move ins" for clients [residents], and "department heads not familiar with new move-ins." HD-B stated no	0 580		

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0 580	Continued From page 2 additional documentation of quality assurance meeting minutes, agendas, or projects from 2022 were completed to evaluate the quality of care. HD-B confirmed "unfortunately we don't have anything for 2022." The licensee's Quality Management Plan policy dated August 1, 2021, verified "the Assisted Living Director will develop a continuous quality improvement and management program to maintain the agency's continuous performance improvement efforts, consistent with current professional standards and the highest quality services for residents. All staff will be involved in the implementation of performance improvement efforts." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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	0 680		

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0 680	Continued From page 3 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). On January 31, at 1:10 p.m., a review of the licensee's emergency management binder was completed with housing director (HD)-B. HD-B stated the emergency preparedness manual did not include all the required information. The binder contained policies on various emergencies such as heat, severe weather emergencies, and emergency evacuations however, the procedures spelled out in the plan were not individualized to the facility.	0 680		

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0 680	Continued From page 4 The facility's plan lacked the following required content: -an assessment of the at risk population's needs; -a process for emergency preparedness (EPS) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies and procedures, based on risk assessment, and additional policies individualized to the facility for: potential evacuation, sheltering in place, handling medical documents. -a plan for sheltering in place when not able to evacuate; -transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services; -a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers, federal, state, tribal, regional, and local emergency preparedness staff, state licensing and certification agency, Office of the State Long Term Care Ombudsman, other sources of assistance, a plan for communicating during an emergency, including primary and alternative means for communication, procedures for sharing medical information to maintain continuity of care; and procedures for sharing the emergency plan with family members and residents. The licensee's Emergency and Disaster Preparedness policy dated August 1, 2021, included "this facility will be prepared to manage	0 680		

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0 680	Continued From page 5 emergency and disaster situations, including missing residents through our hazard vulnerability assessment and emergency operations plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 810		

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0 810	Continued From page 6 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, and staff interview, the facility failed have detailed fire safety and evacuation plans and associated confirming documentation. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: 1. On January 31, 2023 between 08:30 AM TO 11:00 AM, survey staff observed that no documentation was presented during documentation review to confirm that staff are receiving training on fire safety and evacuation upon hire and at least twice per year. Documentation that was available identified that the most recent fire drill was conducted on April 12, 2022. 2. On January 31, 2023 between 08:30 AM TO 11:00 AM, survey staff observed that no documentation was presented during	0 810		

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0 810	Continued From page 7 documentation review to confirm that residents that are capable of assisting in their own evacuation are being trained on the proper actions at least once per year. 3. On January 31, 2023 between 08:30 AM TO 11:00 AM, survey staff observed that no documentation was presented during documentation review to confirm that evacuation drills are being conducted with employees twice per year shift per shift with at least one drill every other month. Housing Director-B verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 8 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initial assessment for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked monitoring and reassessment within 14 days from the initial assessment. R1's signed Individualized Service Plan, dated September 1, 2022, identified diagnoses of chronic obstructive pulmonary disease (COPD) and type 2 diabetes mellitus, and included services for medication administration, blood pressure and blood sugar monitoring.	01620		

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01620	Continued From page 9 On January 31, 2023, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's morning medications and remind him to check his blood sugar. R1's initial assessment was completed on September 30, 2021. R1's record lacked documentation an RN completed a 14-day assessment. On January 31, 2023, at 2:30 p.m., clinical director (CD)-A confirmed the 14-day reassessment was not completed and was missing from R1's record. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated August 1, 2021, "a finalized service plan will be completed no later than 14 calendar days after initiation of services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/31/23*
Time: 08:03:07
Report: 8044231029

Food and Beverage Establishment Inspection Report

Location:
Countryside Catered Senior Liv
650 El Dorado Street
Owatonna, MN55060
Steele County, 74

Establishment Info:
ID #: 0037539
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074468334
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.

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

No quaternary ammonium test kit.

Comply By: 02/07/23

5-200A Plumbing: approved materials/design

5-203.11A ** Priority 2 **

MN Rule 4626.1070A Provide at least 1 handwashing sink, or the number of handwashing sinks necessary to allow for the convenient use by employees during food preparation, food dispensing, and warewashing; and in or adjacent to toilet rooms.

Handwashing sink in dish room has been removed and must be re-installed.

Comply By: 02/28/23

Surface and Equipment Sanitizers

Hot Water: = at 173.6 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41.0 Degrees Fahrenheit - Location: Upright 1
Violation Issued: No

Type: Full
Date: *01/31/23*
Time: 08:03:07
Report: 8044231029
Countryside Catered Senior Liv

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 30.4 Degrees Fahrenheit - Location: Chicken in upright 1
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35.0 Degrees Fahrenheit - Location: Milk in upright 1
Violation Issued: No

Process/Item: Hot Holding
Temperature: 137.8 Degrees Fahrenheit - Location: Eggs
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.0 Degrees Fahrenheit - Location: Prep
Violation Issued: No

Process/Item: Cold Holding
Temperature: 33.0 Degrees Fahrenheit - Location: Upright 2
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40.8 Degrees Fahrenheit - Location: Roast beef in upright 2
Violation Issued: No

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

HRD inspection conducted with lead surveyor Jolene Bertelsen and Tammy Carlson. Inspection report reviewed on site with Dining Manager, Lana.

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 8044231029 of 01/31/23.

Certified Food Protection Manager: Lana J. Purdie

Certification Number: FM96334 Expires: 11/16/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Lana

Signed: _____

Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us