



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 16, 2025

Licensee
A Daughters Love Inc.
25184 Thunder Road
Staples, MN 56479

RE: Project Number(s) SL36902016

Dear Licensee:

On August 29, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 6, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 6, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 6, 2025, found not corrected at the time of the August 29, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0830 - Local Laws Apply - 144g.45 Subd. 3 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on August 29, 2025 (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.

Also, at the time of this follow-up survey completed on August 29, 2025, we identified the following violation(s):

0340 - Correction Orders - 144g.30 Subd. 5 - \$500.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not

required to be submitted for approval.

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

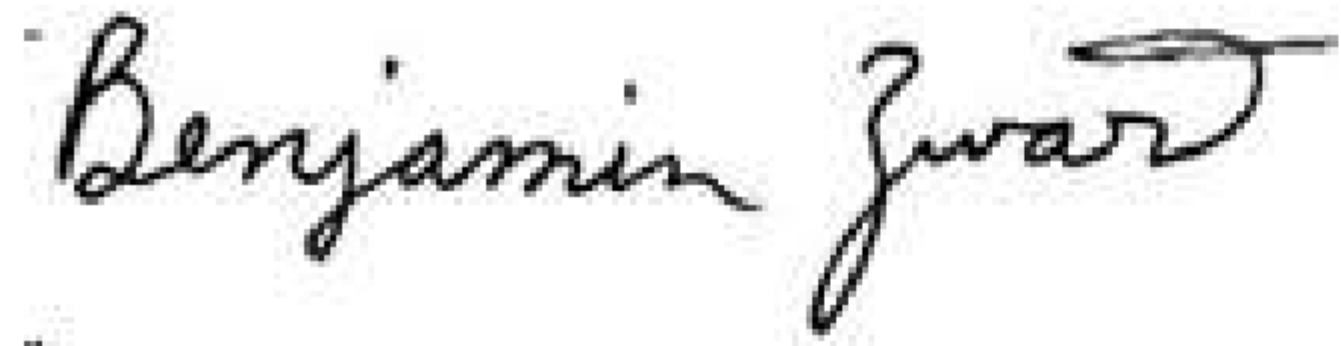
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To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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

Sincerely,

A handwritten signature in black ink that reads "Benjamin J. Zwart". The signature is written in a cursive style with a horizontal line at the end.

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36902	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/29/2025
NAME OF PROVIDER OR SUPPLIER A DAUGHTERS LOVE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 25184 THUNDER ROAD STAPLES, MN 56479			
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS: SL36902016-2 On August 29, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 29, 2025. As a result of the follow-up survey, the following orders were reissued.	{0 000}			
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The	0 340			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1 commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to complete actions to comply with correction orders from a survey completed on February 3, 2025, and reissued May 29, 2025. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. 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 of the residents). The findings include: During surveys conducted on February 3, 2025, and May 29, 2025, the licensee was cited using the 0830 tag identification number for unpermitted construction work that included construction of a building addition and emergency exiting modifications. On August 29, 2025, at 9:22 a.m., during the second follow-up survey, the surveyor emailed the licensee and requested a plan of correction	0 340			

Minnesota Department of Health

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0 340	Continued From page 2 for the 0830 tag. On August 29, 2025, at 3:52 p.m., the licensee responded attached are the completed architecture plans of the building. Record review indicated the attached plans were not certified by a licensed architect. A plan of correction was not provided. The surveyor contacted the Department of Labor and Industry (DLI) and requested an update from Construction Codes and Licensing. DLI responded nothing had been received from licensee in response to the email dated May 30, 2025. Additionally, as of August 29, 2025, a plan review application including the required certified plan had not been submitted to Minnesota Department of Health Engineering Services. Previous survey 0830 tag identification number findings: On May 28, 2025, owner (O)-B provided a copy of the land use permit from Todd County dated March 11, 2025, for a dwelling unit expansion. On May 28, 2025, at 10:35 a.m., during the first follow-up survey, the surveyor toured the facility with O-B. During the tour, the surveyor observed four illuminated exit signs had been removed in the addition. During an interview on May 28, 2025, at 11:30 a.m., O-B verified the exit sign removal and stated the emergency exiting plan for the building was included as part of the architectural review currently underway. O-B stated the licensee was not satisfied with the first architect hired for the project and was now working with another company. On May 29, 2025, O-B provided a copy of a letter of intent for architectural services dated April 30, 2025. The letter of intent indicated the project would include a central bathing remodel and creation of MDH	0 340			

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0 340	Continued From page 3 record drawings of the existing building. On May 30, 2025, the surveyor received an email from the Department of Labor and Industry (DLI). The email indicated the licensee had not submitted an application to the Construction Codes and Licensing Division and an architectural plan would be required before the licensee could apply. On May 30, 2025, the DLI building plan review lead emailed the licensee information on plan review, permits, and inspections from DLI Construction Codes and Licensing required for all buildings licensed for assisted living. Additionally, as of May 30, 2025, a plan review application including the required certified plan had not been submitted to Minnesota Department of Health Engineering Services. On February 3, 2025, at 11:15 a.m., the surveyor toured the facility with manager (M)-C. During the tour, the surveyor observed the following: 1. Occupied resident sleeping rooms 10/11 and 12 and an employee office were located in the part of the facility referred to as the addition. Inspection stickers on the electrical panels indicated electrical work was completed in the facility between August 2, 2021, and February 28, 2022. During the facility tour interview, M-C stated they did not know what year the addition was constructed. 2. On February 6, 2025, at 8:25 a.m., the surveyor emailed the owner (O)-B requesting copies of the building permit and certificate of occupancy for the addition. On February 6, 2025, at 9:16 a.m., O-B emailed they would check with the builders but they were pretty sure they did not have a permit as the facility is located in the county and not the city. O-B indicated that when	0 340			

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0 340	Continued From page 4 they originally purchased the property, they did recall checking with both and were pretty certain they did not need a permit. 3. On February 6, 2025, at 4:13 p.m., the surveyor emailed O-B requesting the dates when the construction of the addition started and when the project was complete. On February 10, 2025, at 9:20 p.m., O-B responded construction started in June 2021 and finished in September 2021, as that is when the last payment was made. Additionally the final electrical inspection from Department of Labor and Industry was completed on August 2, 2021. 4. The Department of Labor and Industry emailed the surveyor on February 12, 2025, and verified the property owner failed to obtain the required land use permits from Todd County for the building addition. A copy of the Conditional Use Permit (CUP) dated August 20, 2020, was attached to the email. The CUP indicated the proposed use allowed no more than 15 residents and an expansion beyond this number must be reviewed by the planning commission. The Minnesota Department of Health assisted living license indicated a current license capacity of 18 residents. The surveyor verified a Minnesota Department of Health Engineering Services plan review application had not been submitted for the building addition. New construction plans for work beginning on or after August 1, 2021, requires plan review by Minnesota Department of Health Engineering Services. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			

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{0 480}	Continued From page 5	{0 480}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	{0 480}			

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{0 480}	Continued From page 6 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}			

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{0 790}	Continued From page 7	{0 790}	Not reviewed during this survey.		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.		
{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) staff 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) Staff of assisted living facilities shall receive	{0 810}			

Minnesota Department of Health
STATE FORM 6899 UFC013 If continuation sheet 9 of 11

Minnesota Department of Health

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{0 830}	Continued From page 9 by: Based on record review and interview, the licensee failed to submit applications to the Department of Labor and Industry and Minnesota Department of Health Engineering Services for construction of a building addition and emergency exiting modifications. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2025, at 9:22 a.m., the surveyor emailed the licensee and requested a plan of correction for the 0830 tag. On August 29, 2025, at 3:52 p.m., the licensee responded attached are the completed architecture plans of the building. Record review indicated the attached plans were not certified by a licensed architect. A plan of correction was not provided. The surveyor contacted the Department of Labor and Industry (DLI) and requested an update from Construction Codes and Licensing. DLI responded nothing had been received from licensee in response to the email dated May 30, 2025. Additionally, as of August 29, 2025, a plan review application including the required certified plan had not been submitted to Minnesota Department of Health Engineering Services.	{0 830}			

Minnesota Department of Health
STATE FORM 6899 UFC013 If continuation sheet 11 of 11



Protecting, Maintaining and Improving the Health of All Minnesotans

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August 6, 2025

Licensee

A Daughters Love Inc
25184 Thunder Road
Staples, MN 56479

RE: Project Number(s) SL36902016

Dear Licensee:

On May 29, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 6, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 6, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 6, 2025, found not corrected at the time of the May 29, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on May 29, 2025 (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 approximately 30 days after receipt of this notice, subject to appeal.

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We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,



Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS: SL36901016-1 On May 27, 2025, through May 29, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on February 6, 2025. At the time of the survey, there were 14 residents receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36902	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/29/2025
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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code, under Minnesota Rules Chapter 7511. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 3 or has the potential to affect a large portion or all of the residents). The findings include: On May 28, 2025, at 10:35 a.m., the surveyor toured the facility with owner (O)-B. During the tour, the surveyor observed the following: - In the covered patio area, near the side living room door, burnt cigarettes were on the ground at the corner of the building. - Burnt cigarettes were on the lawn in multiple locations around the building. - In an employee smoking area at the back of the building, outside the office door, burnt cigarettes had been disposed of in an uncovered can sitting on a wood table. - In an employee smoking area on the back of the building, outside the dining room door, burnt cigarettes were disposed of in a metal can with a plastic lid stored on a plastic table. - There was an uncovered metal bucket with two burnt cigarettes in the bottom stored next to the building by the main entrance sidewalk. - In the designated smoking area near the main entrance, burnt cigarettes were disposed of in the bottom of an uncovered metal bucket stored on the lawn and an unattended ashtray contained burnt cigarettes. - In the designated smoking area on the back patio, burnt cigarettes were disposed in the bottom of an uncovered metal bucket. During the facility tour interview on May 28, 2025, O-B verified the smoking material disposal observations and stated proper smoking areas would be designated and new disposal containers would be purchased. Previous survey 0775 tag identification number	{0 775}			

Minnesota Department of Health
STATE FORM 6899 UFC012 If continuation sheet 5 of 10

Minnesota Department of Health

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{0 790}	Continued From page 5	{0 790}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	{0 800}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{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) staff 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	{0 810}			

Minnesota Department of Health
STATE FORM 6899 UFC012 If continuation sheet 7 of 10

Minnesota Department of Health

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{0 830}	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to submit applications to the Department of Labor and Industry and Minnesota Department of Health Engineering Services for construction of a building addition and emergency exiting modifications. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 28, 2025, owner (O)-B provided a copy of the land use permit from Todd County dated March 11, 2025, for a dwelling unit expansion. On May 28, 2025, at 10:35 a.m., the surveyor toured the facility with O-B. During the tour, the surveyor observed four illuminated exit signs had been removed in the addition. During an interview on May 28, 2025, at 11:30 a.m., O-B verified the exit sign removal and stated the emergency exiting plan for the building was included as part of the architectural review currently underway. O-B stated the licensee was not satisfied with the first architect hired for the project and was now working with another company. On May 29, 2025, O-B provided a copy of a letter of intent for architectural services dated April 30, 2025. The	{0 830}			

Minnesota Department of Health

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{0 830}	Continued From page 8 letter of intent indicated the project would include a central bathing remodel and creation of MDH record drawings of the existing building. On May 30, 2025, the surveyor received an email from the Department of Labor and Industry (DLI). The email indicated the licensee had not submitted an application to the Construction Codes and Licensing Division and an architectural plan would be required before the licensee could apply. On May 30, 2025, the DLI building plan review lead emailed the licensee information on plan review, permits, and inspections from DLI Construction Codes and Licensing required for all buildings licensed for assisted living. Additionally, as of May 30, 2025, a plan review application including the required certified plan had not been submitted to Minnesota Department of Health Engineering Services. Previous survey 0830 tag identification number findings: On February 3, 2025, at 11:15 a.m., the surveyor toured the facility with manager (M)-C. During the tour, the surveyor observed the following: 1. Occupied resident sleeping rooms 10/11 and 12 and an employee office were located in the part of the facility referred to as the addition. Inspection stickers on the electrical panels indicated electrical work was completed in the facility between August 2, 2021, and February 28, 2022. During the facility tour interview, M-C stated they did not know what year the addition was constructed. 2. On February 6, 2025, at 8:25 a.m., the surveyor emailed the owner (O)-B requesting copies of the building permit and certificate of occupancy for the addition. On February 6, 2025,	{0 830}			

Minnesota Department of Health

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{0 830}	Continued From page 9 at 9:16 a.m., O-B emailed they would check with the builders but they were pretty sure they did not have a permit as the facility is located in the county and not the city. O-B indicated that when they originally purchased the property, they did recall checking with both and were pretty certain they did not need a permit. 3. On February 6, 2025, at 4:13 p.m., the surveyor emailed O-B requesting the dates when the construction of the addition started and when the project was complete. On February 10, 2025, at 9:20 p.m., O-B responded construction started in June 2021 and finished in September 2021, as that is when the last payment was made. Additionally the final electrical inspection from Department of Labor and Industry was completed on August 2, 2021. 4. The Department of Labor and Industry emailed the surveyor on February 12, 2025, and verified the property owner failed to obtain the required land use permits from Todd County for the building addition. A copy of the Conditional Use Permit (CUP) dated August 20, 2020, was attached to the email. The CUP indicated the proposed use allowed no more than 15 residents and an expansion beyond this number must be reviewed by the planning commission. The Minnesota Department of Health assisted living license indicated a current license capacity of 18 residents. The surveyor verified a Minnesota Department of Health Engineering Services plan review application had not been submitted for the building addition. New construction plans for work beginning on or after August 1, 2021, requires plan review by Minnesota Department of Health Engineering Services. No further information was provided.	{0 830}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 28, 2025

Licensee

A Daughters Love Inc
25184 Thunder Road
Staples, MN 56479

RE: Project Number(s) SL36902016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 6, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

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

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

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - \$3,000.00

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - \$3,000.00

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - \$3,000.00

St - 0 - 1880 - 144g.71 Subd. 19 - Storage Of Medications - \$3,000.00

St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - \$3,000.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$21,500.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with A Daughters Love Inc. Please contact Jessie Chenze at 218-332-5175 **on or before March 5, 2025**, to schedule the conference call.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEphVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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0 000	Initial Comments 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: SL36902016-0 On February 3, 2025, through February 6, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 15 residents; 15 receiving services under the assisted living facility license. Immediate correction orders were identified on February 4, 2025, for project SL36902016-0, for tag identification 0110, 1620, and 1880. Tags 0110 and 1880 were issued at a scope and level of widespread level three (I) and tag 1620 was issued at a scope and level of isolated level three (G). An immediate correction order was identified on February 5, 2025, for project SL36902016-0 for tag identification 1290, issued at a scope and level of widespread level three (I). Immediate correction orders were identified on February 6, 2025, for project SL36902016-0, for	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 000	Continued From page 1	0 000			
0 110 SS=I	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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD) licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's residents, staff, and visitors. This resulted in an immediate correction order issued on February 4, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 3, 2025, at 8:00 a.m., the surveyor	0 110			

Minnesota Department of Health

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0 110	Continued From page 2 reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website. The BELTSS website indicated the licensee had an assisted living director in residency (ALDIR)-A and was issued on November 7, 2023. The BELTSS website indicated the residency permit for the licensee's ALDIR-A expired on November 6, 2024. During the entrance conference on February 3, 2025, at 10:20 a.m., owner (O)-B stated ALDIR-A did not pass the tests for the BELTSS license. O-B stated ALDIR-A had been in contact with BELTSS to figure out how to proceed. O-B stated the licensee did not have a LALD currently. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	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	0 470			

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0 470	Continued From page 3 requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed a staffing plan to determine staffing levels to meet the needs of all residents and ensure the staffing plan was reviewed at a minimum of twice a year 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) 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 finding include: The licensee held an assisted living facility license and was licensed for a census of 18 residents, with a current census of 15 residents. During the entrance conference on February 3, 2025, at 10:00 a.m., the surveyor requested a	0 470			

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0 470	Continued From page 4 copy of the licensee's staffing plan from the owner (O)-B and manager (M)-C. On February 3, 2025, at 12:00 p.m., O-B emailed (electronic mail) the surveyor a staffing plan and schedule posting audit dated October 3, 2024, however, lacked a developed staffing plan. On February 3, 2025, at 4:40 p.m., O-B emailed the surveyor a leadership meeting dated August 6, 2024, and an undated, bi-yearly staffing plan to be used for future specific staffing notes. The licensee failed to provide a developed staffing plan to include the following: - includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - 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 - 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. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. No further information was provided.	0 470			

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0 470	Continued From page 5	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its	0 480			

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0 480	Continued From page 6 existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report	0 480			

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0 480	Continued From page 7 (FBEIR) dated February 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that	0 500			

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0 500	Continued From page 8 staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee was familiar with current minimum assisted living requirements.	0 500			

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0 500	Continued From page 9 On November 9, 2024, at 1:00 a.m., handwritten notes in R4's resident record, indicated significant injuries (laceration on leg, and a "goose egg" to the head), however a report was not made to Minnesota Adult Abuse Reporting Center (MAARC). On January 19, 2025, at 1:19 p.m., R1's progress notes indicated significant injuries (discolored and blistered hands), however a report was not made to MAARC. On February 4, 2025, from 8:15 a.m. to 8:40 a.m., the surveyor interviewed clinical nurse supervisor (CNS) -D. CNS-D stated CNS-D was not aware of when to make a report to MAARC and CNS-D would need to look at the licensee's policy. The licensee failed to ensure the licensee had a policy and procedure in place and kept current for requirements in section 626.557, reporting of maltreatment of vulnerable adults. A policy was requested, however, was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
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.	0 510			

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0 510	Continued From page 10 (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 that complied with accepted health care, medical and nursing standards for infection control related to COVID-19 for two of two residents (R6, R12). This had the potential to affect all 15 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's COVID-19 Resident and Employee Screening and Safety policy reviewed on January 27, 2022, and February 5, 2025, (after survey entrance), respectively, indicated to continue to identify early onset symptoms (cough, fever, sore throat, new or worsening shortness of breath) via the sign in sheet tracker for staff, visitors and ancillary visitors. Registered nurse	0 510			

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0 510	Continued From page 11 (RN) director to be notified immediately of any new symptoms. In addition, the COVID-19 policy indicated the following: - Any visitors (hospice) will be screened via the COVID 19 questionnaire. These questionnaires will be kept in RN Director possession; - Staff will not report to work with known symptoms and will alert RN director to new onset symptoms; - Staff with symptoms of respiratory illness, diarrhea, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion, runny nose, nausea or vomiting will be off work for 5 days from the day the symptoms first appeared; - Clean the thermometer, O2 (oxygen saturations monitor), and any vitals machines with alcohol-based solution and or disinfectant wipes or sprays that have been approved by management; - Check the sheet for usage directions of each individual brand or type and allow to dry between each use according to the data sheet that has been provided (these data sheets are hung in various locations); - Alert RN director to temperatures above 99.5 Fahrenheit (F) in staff or resident; - If a resident does develop any of the above symptoms, he/she will need to remain isolated in his/her room and nurse contacted for further direction; - Bedroom and bathroom privileges on isolation, provide a commode for each resident if possible. If a resident who is displaying symptoms uses the bathroom, staff to clean the sink, toilet, counter and door with alcohol and or bleach wipes; - If the resident needs to come out of his/her room, they must wear a mask. The trips out of the bedroom must be limited to bathroom breaks, short trips outside for fresh air, etc.;	0 510			

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0 510	Continued From page 12 - Staff caring for a possible COVID 19 resident must wear proper personal protective equipment (PPE), gown, gloves, goggles and mask; - Residents remain in isolation for five days after the start of symptoms, if no symptoms, the five days starts the day of positive test; - RN director to communicate change in status of resident to medical doctor (MD), families, social workers; - Residents to be brought to a testing facility if MD requests testing for COVID 19; - RN director to contact Minnesota Department of Health (MDH) and resident's primary MD to report resident symptoms and/or test results; - All items used by residents will be cleaned with bleach sanitary wipes; and - Facility to limit resident contact and if possible, have the same staff member care for the COVID-19 resident(s). The licensee failed to implement the licensee's COVID-19 procedures and the licensee failed to have staff wear appropriate PPE for COVID-19 guidelines. In addition, the licensee failed to screen residents, staff, and visitors for signs and symptoms of COVID-19. On February 5, 2025, at 6:05 a.m., the surveyor received an email (electronic mail) from owner (O)-B, which indicated a resident was sent into the emergency department last night, the resident was sent home, and the resident had tested positive for COVID-19. On February 5, 2025, at 9:02 a.m., the surveyors entered the facility. A sign was posted on the main entrance door and had written, "ENTER AT YOUR OWN RISK WE DO HAVE COVID IN THE HOUSE! We apologize for any inconvenience if we have not gotten ahold of you yet! [sic]" The	0 510			

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0 510	Continued From page 13 surveyors opened the main door of the facility and staff present were unlicensed personnel (ULP)-F, ULP-G, ULP-K, manager (M)-C, and residents. The surveyors did not observe ULP-F, ULP-G, ULP-K, or M-C wearing masks or goggles. The surveyors were not screened for COVID-19 symptoms upon entry to the facility. On February 5, 2025, at 9:15 a.m., the surveyor observed a cart outside of R6's door with disinfectant wipes, gloves, surgical masks, N95 masks, gowns, garbage bags, and hand sanitizer. A paper placed on the cart indicated how to apply and remove gloves, gown, goggles, and facemasks before and after leaving a resident room. On February 5, 2025, at 9:22 a.m., ULP-G stated ULPs only test staff or residents if they appear to have signs or symptoms of COVID-19. On February 5, 2025, at 9:51 a.m., the surveyor observed ULP-G wearing a surgical mask. On February 5, 2025, at 10:03 a.m., ULP-F stated PPE (mask, gown, gloves, goggles) were only required to be worn while in R6's room. On February 5, 2025, at 10:10 a.m., clinical nurse supervisor (CNS)-D arrived at the facility. The surveyor did not observe CNS-D wearing a mask or goggles. On February 5, 2025, at 10:17 a.m., the surveyor observed CNS-D wearing a surgical mask. CNS-D stated R6 was isolated to R6's room for the next five days due to a positive COVID-19 test after going to the emergency department last night. CNS-D stated ULPs were required to wear gloves, a gown, mask, and goggles before	0 510			

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0 510	Continued From page 14 entering R6's room, and ULPs were to remove the PPE prior to leaving R6's room. CNS-D further stated residents, or staff would only test for COVID-19 if they were to become symptomatic of COVID-19. The surveyor requested to review the licensee's COVID-19 policy. On February 5, 2025, at 10:23 a.m., ULP-F stated surgical masks were implemented to be worn throughout the facility this morning upon CNS-D's arrival to the facility. On February 5, 2025, at 10:26 a.m., the surveyor observed ULP-K wearing a mask below ULP-K's nose, and ULP-K was assisting R8 with positioning a pillow around R8's neck. On February 5, 2025, at 11:19 a.m., CNS-D inquired to the surveyors about current PPE guidelines regarding COVID-19 and where to find the current COVID-19 guidelines. CNS-D further stated CNS-D was not sure if the current COVID-19 guidelines required staff to wear goggles or not. The surveyor stated to follow what the licensee currently had in place for COVID-19, and the surveyor requested again to review the current COVID-19 policy. On February 5, 2025, at 11:45 a.m., the surveyor observed ULP-F and ULP-G putting on an N95 mask, gown, gloves, and goggles before entering R6's room. ULP-F and ULP-G stated ULPs were not instructed to screen residents' temperatures daily unless the residents were to become symptomatic of COVID-19, and ULPs were not instructed to screen visitors upon entry to the facility. At 11:55 a.m., the surveyor observed ULP-G enter the hallway outside of R6's room and removed ULP-G's gloves, gown, N95 mask,	0 510			

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0 510	Continued From page 15 and goggles. ULP-G placed the gloves, gown, and N95 mask in the garbage can located in the hallway outside of R6's room, disinfected ULP-G's goggles, and completed hand hygiene. On February 5, 2025, at 12:01 p.m., ULP-F stated when CNS-D arrived this morning ULPs were instructed to remove all PPE prior to exiting R6's room. On February 5, 2025, at 12:15 p.m., the surveyor observed M-C wearing a surgical mask placed below M-C's nose while conversing with CNS-D. On February 6, 2025, at 10:55 a.m., ULP-E stated ULPs were not instructed to screen residents daily for signs and symptoms COVID-19 unless a resident had become symptomatic of COVID-19. ULP-E further stated R12 had tested positive for COVID-19 today (February 6, 2025). On February 6, 2025, at 10:56 a.m., the surveyor observed signage on R12's door, which indicated R12's room was an isolation room, and R12 was positive for COVID-19. The surveyor did not observe any PPE supplies placed outside of R12's room. On February 6, 2025, at 10:58 a.m., CNS-D stated R12 was tested for COVID-19 this morning (February 6, 2025) due to a sore throat, R12's COVID-19 test came back positive, and CNS-D was going to report the R12's positive COVID-19 test to MDH. The surveyor requested to be informed of when CNS-D notified MDH of R12's positive COVID-19 test, however, the surveyor never received any update from CNS-D. CNS-D further stated the licensee was in the process of setting up a PPE cart outside of R12's room.	0 510			

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0 510	Continued From page 16 CNS-D stated residents were only being tested for COVID-19 if the resident became symptomatic of COVID-19, however, residents were not being screened by ULPs. On February 6, 2025, at 11:10 a.m., the surveyor did not observe any PPE supplies placed outside of R12's room. On February 6, 2025, at 2:03 p.m., ULP-E stated R8 was sweating, had a high reading blood pressure, however, did not have a temperature. ULP-E stated ULP-E performed a COVID-19 test for R8 in the living area where other residents were present and was awaiting the results. On February 6, 2025, at 2:23 p.m., ULP-E stated to CNS-D R8's COVID-9 test was negative. The licensee's 8.01 Infection Control Policy dated August 1, 2021, indicated infection control practices are important for the health and safety of both staff, residents, and guests. The facility has a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. The Center of Disease Control and Prevention (CDC) Infection Control Guidance: SARS-COV-2 dated June 24, 2024, indicated recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic: - Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeteria). These alerts should include instructions about IPC recommendations (when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations;	0 510			

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0 510	Continued From page 17 - Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria: a positive viral test for SARS-CoV-2, symptoms of COVID-19, or close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higher-risk exposure (for healthcare personnel (HCP); - Implement source control measures. Source control measures refer to the use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing or coughing. People, particularly those at high risk of severe illness, should wear the most protective mask or respirator they can that fits well and that they will consistently wear. Even when a facility does not require masking for source control, it should allow individuals to use a mask or respirator based on personal preference, informed by their perceived level of risk of infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease if they are exposed; - Source control is recommended for individuals in healthcare settings who: have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with a runny nose, cough sneeze); or had close contact (patients and visitors) or a higher risk exposure (HCP) with someone SARS-CoV-2 infection, for 10 days after their exposure; - Source control is recommended more broadly as described in CDC's Core IPC Practices in the following circumstances: by those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infections; universal use of source	0 510			

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0 510	Continued From page 18 control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection has been identified for 14 days, or facility wide or, based on facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients with moderate or severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission; and - Implement universal use of personal protective equipment for HCP. As SARS-CoV-2 transmission in the community increases, the potential for encountering asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection also likely increases. In these circumstances, healthcare facilities should consider implementing broader use of respirators and eye protection by HCP during the patient care encounters. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities	0 550			

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0 550	Continued From page 19 and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on February 3, 2025, at 11:05 a.m., the surveyor did not observe the required posting related to the licensee's grievance procedure. On February 6, 2025, at 2:07 a.m., manager (M)-C stated the grievance procedure was posted on the information board and stated it must have gotten taken down when the walls were painted last summer. No further information was provided.	0 550			

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0 550	Continued From page 20	0 550			
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 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 engage in and maintain documentation of a quality management activity appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 15 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) 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).	0 580			

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0 580	Continued From page 21 The findings include: During the entrance conference on February 3, 2025, at 10:00 a.m., the surveyor requested the quality management plan, policy, and documentation from the last twelve months from owner (O)-B and manager (M)-C. On February 5, 2025, at 12:45 p.m., the surveyor asked clinical nurse supervisor (CNS)-D if CNS-D had a quality management plan. CNS-D stated we (the licensee) had monthly zoom meetings, and O-B would have that information. The surveyor asked what the current focus was for quality management. CNS-D stated, "we are coming up with one." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 620 SS=F	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury	0 620			

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0 620	Continued From page 22 which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event	0 620			

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0 620	Continued From page 23 meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for three of three residents (R1, R4, R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 3, 2025, at 10:00 a.m., the surveyor asked what the vulnerable adult reporting expectations were for the facility. Manager (M)-C stated, "I don't know," and owner (O)-B stated, "Anybody can report, if staff think someone is being abused, like mentally or physically." On February 5, 2025, at 10:37 a.m., the surveyor received an email (electronic mail) from O-B which indicated the licensee had not filed any MAARC reports for the past six months. R1	0 620			

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0 620	Continued From page 24 R1's diagnoses included traumatic brain injury and left sided weakness. R1's Service Plan dated June 7, 2024, indicated R1 received medication administration, assistance with bathing, dressing, grooming, monthly vitals, incontinence cares, brace/splint application and removal, high behavior management, smoking assistance, housekeeping, and laundry. R1's Individual Abuse Prevention Plan (IAPP) dated September 23, 2024, did not indicate R1 smoked, however, did indicate R1 was at risk of self-abuse due to impaired judgement. On February 4, 2025, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-F and ULP-G perform morning cares for R1. The surveyor observed on R1's right hand a bandage on his fourth finger, black areas of skin on the tips of R1's second and third fingers, various other blackened areas from the second knuckle to the tip of R1's finger, and R1's left hand had a bandage on R1's third finger. ULP-F and ULP-G stated the blackened areas were frostbite from when it was 45 degrees below zero Fahrenheit (F). ULP-G stated R1 was a smoker and thought it was from R1 going outside to smoke. ULP-F stated it was a couple of weeks ago, ULP-F was working with ULP-E, and noticed blisters and discoloration on R1's fingers one morning (around January 19, 2025, ULP-E thought). ULP-F stated clinical nurse supervisor (CNS)-D was called and the ULPs sent pictures to CNS-D of R1's fingers as they thought R1's fingers had frostbite. CNS-D told the ULPs CNS-D was sending the picture to R1's provider. ULP-F and ULP-G stated R1's fingers continued to turn blue, and get darker and darker, as the days went by.	0 620			

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0 620	Continued From page 25 ULP-F and ULP-G stated they reached out to CNS-D again the next day, however, CNS-D did not come in to assess R1's hands. On February 4, 2025, from 8:15 a.m. to 8:40 a.m., the surveyor interviewed CNS-D via phone. CNS-D stated CNS-D was notified of blisters on R1's hands on January 19, 2025, and did not assess R1 until January 21, 2025. CNS-D stated CNS-D had conversed with R1's provider and staff through pictures on the phone that were being sent to CNS-D. CNS-D did not recall if CNS-D filled out an incident report, however, CNS-D indicated CNS-D had documented in R1's notes. CNS-D further stated CNS-D did not think to report R1's hands condition to MAARC, CNS-D was not aware of when to report to MAARC, and CNS-D would need to look at the licensee's policy. The licensee failed to report suspected neglect after R1 experienced blisters and discoloration to hands after ULPs suspected R1 had frostbite. CNS-D did not investigate or assess R1 until two days after notification from ULPs, and R1 did not see a provider for three days after presenting with worsening blisters and continued discoloration of R1's fingers. R4 R4's diagnosis included unspecified dementia with behavior disturbance. R4's Service Plan dated January 22, 2025, indicated R4 received medication administration, TEDS (compression stockings), monitoring vital signs, and assistance with bathing, grooming, dressing, and light housekeeping. R4's IAPP dated January 22, 2025, indicated R4's	0 620			

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0 620	Continued From page 26 decision making skills were slightly impaired. In addition, the IAPP indicated R4 had approximately three falls in the last three months. On February 5, 2025, at 9:54 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R4. R4's Resident Notes-One Resident dated November 9, 2024, had a written entry which indicated the ULPs contacted CNS-D on November 9, 2024, at 1:00 a.m. regarding R4 was found of the floor at the foot of R8's bed. R4 had a laceration to lower left leg and "goose egg" to R4's head. R4 went to the ER (emergency room), had a CT (cat scan) of R4's head and spine. R4 received 12 sutures to R4's leg laceration. R4 returned to the facility with a diagnosis of fall, open wound of leg, and contusion of scalp. The licensee failed to make a MAARC report for R4's unexplained significant injuries. R8 R8's diagnoses included dementia. R8's unsigned Service Plan dated February 5, 2025, (completed after survey entrance), indicated R8 received medication management, assistance with incontinent cares, toileting, repositioning, compression stockings, bathing, dressing, grooming, ambulation, smoking, monthly vital signs, laundry, and housekeeping. R8's 90-day assessment dated November 14, 2024, indicated R8 had a standard bed frame, original mattress to the bed and no assistive devices needed for bed. R8's assessment indicated R8 needed 24-hour supervision and	0 620			

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0 620	Continued From page 27 staff will observe resident from potentially abusive/harmful situations. R8's assessment indicated staff are to check residents brief for incontinence during repositioning every two hours at night and assist resident with cares if needed. On February 5, 2025, at 2:43 p.m., the surveyor observed R8's hospital bed had one left single upper hospital bed rail in the upright position. On September 24, 2024, at 10:30 p.m., an incident report indicated R8 was found by a ULP half on the floor and half on the bed when checking on R8, as R8 was yelling. The ULP indicated in the report R8 was hanging on to the side rail of the bed and R8's butt and legs were on the floor. R8 stated R8 was trying to get up, as R8 was tired of laying down. The ULP also indicated on the report R8's bed alarm was unplugged. ULP indicated R8 had a bruise (no location), M-C was notified via phone at 10:34 p.m., to assist with getting R8 off the floor. Registered Nurse (RN)-J was notified at 11:04 p.m. RN-J documented on September 26, 2024, R8 was assisted off the floor, R8 was assessed for injuries, and R8 was educated on importance to call for help. The licensee failed to immediately report suspected neglect after R8 was found hanging from the hospital bed rail on R8's bed. R8's record lacked an updated assessment completed by an RN to ensure a bed rail assessment was completed to ensure the hospital bed rail was not an entrapment risk. On December 27, 2024, at 12:30 a.m., an incident report indicated possible neglect for a ULP on night shift who admitted to not completing R8's bi-hourly checks for repositioning and	0 620			

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0 620	Continued From page 28 changing. The next morning ULPs found R8 was soiled with urine through two chux (an absorbent disposable pad) his sheet and down to his bed (mattress). Incident report indicated the house manager was aware of the incident. No other investigation or follow-up was indicated on the incident report. The licensee failed to immediately report suspected neglect after R8 was found soiled with urine in his bed after staff admitted to not following R8's care plan, to include, checking incontinency products and repositioning every two hours. On February 5, 2025, at 11:45 a.m., CNS-D stated staff would start the incident report and the RN would complete the report within twenty-four hours. CNS-D stated the RN would assess the situation, and add interventions to the care plan as needed. CNS-D stated once an incident report is a month old, the RN can see the report, but can not add to the report. CNS-B stated CNS-B is unsure why the incident reports were not completed or why they were not reported to MAARC. On February 5, 2025, at 12:05 p.m., CNS-D states CNS-D is unsure why the above noted incident reports for R8 were not investigated and reported to MAARC. On February 6, 2025, at 9:52 a.m., RN-J stated RN-J had only worked for the licensee for a short time and was "just helping out." RN-J stated RN-J had helped completing an assessment or two for the licensee at times, however, was not sure the licensee requirements for resident assessments. A policy was requested, however, was not	0 620			

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0 620	Continued From page 29 provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in the commons area to include posting the 911 emergency number, and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all 15 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 640			

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0 640	Continued From page 30 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 February 3, 2025, at 11:05 a.m., during the facility tour, the surveyor did not observe the required postings for the MAARC reporting number or the 911 emergency number. On February 6, 2025, at 2:09 a.m., manager (M)-C stated the MAARC contact information and 911 emergency number was posted on the information board and stated it must have gotten taken down when the walls were painted last summer. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees,	0 660			

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0 660	Continued From page 31 contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a facility risk assessment. 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 February 3, 2025, at 10:00 a.m., the surveyor requested to review the completed TB facility risk assessment. Owner (O)-B stated O-B would need to find the TB risk assessment. On February 5, 2024, at 12:36 p.m., the surveyor asked clinical nurse supervisor (CNS)-D for the completed TB risk assessment. CNS-D stated the TB risk assessment was not completed and CNS-D was unaware of the annual TB risk assessment requirement.	0 660			

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0 660	Continued From page 32 The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated the facility will identify an individual staff member responsible for the TB program. The facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that the appropriate records for nine of nine residents (R1, R2, R4, R5, R6, R7, R8, R9, R10), were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 720			

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0 720	Continued From page 33 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 February 3, 2025, at 10:00 a.m., owner (O)-B stated via phone all resident records were electronic and O-B would email or try and set up surveyor access to the electronic health record. O-B stated employees records were paper and electronic form. O-B stated employee paper records were in secured file cabinets in a detached building within walking distance, manager (M)-C had access to the building, and M-C would retrieve what is needed for employee records. On February 4, 2025, at 9:24 a.m., the surveyor requested R1's record via email (electronic mail) to O-B including signed physician orders. On February 5, 2025, at 2:01 p.m., the surveyor emailed O-B and clinical nurse supervisor (CNS)-D, indicating the surveyor was unable to access information in electronic health record, and requested records for R1, R2, and R4. On February 5, 2025, at 4:43 p.m., the surveyor emailed O-B and CNS-D requesting resident record documentation that had not provided to the surveyors for R2, R4, R5, R6, R7, R8, R9, and R10. On February 6, 2025, at 12:17 p.m., M-C stated M-C had additional information to provide, however, M-C's printer was currently jammed and was unable to use.	0 720			

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0 720	Continued From page 34 On February 6, 2025, at 1:49 p.m., the surveyor emailed O-B and CNS-D requesting resident record documentation, which had had not provided to the surveyors for R2, R4, R5, R6, R7, and R10. On February 6, 2025, at 2:40 p.m., O-B stated O-B emailed over all resident requested information earlier today. The surveyor stated to O-B the resident information from the email on February 6, 2025, at 1:49 p.m., had not been received from O-B, and to submit the requested resident information no later than 5:00 p.m., today (February 6, 2025). O-B further stated O-B had already emailed the information and O-B didn't like having to do the work (emailing the resident information) twice. On February 6, 2025, at 3:01 p.m., O-B stated O-B had to download resident orders one at a time. O-B further stated the licensee's IT (technical support) for the resident's electronic resident medical records was gone until next Tuesday (February 11, 2025) to assist O-B with providing resident record information which was requested by surveyors. On February 6, 2025. at 3:27 p.m., surveyor received a zip file on R2, however, the file did not contain 90-day assessments as requested. On February 6, 2025, at 4:11 p.m., during the exit conference, O-B, CNS-D, and M-C were informed to email requested information noted above to the surveyors by 5:00 p.m. R1's record lacked signed prescriber orders, R2's record lacked 90-day assessments, R4's record lacked signed prescriber orders and 90- day assessments, and R5's record lacked 90-day	0 720			

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0 720	Continued From page 35 assessments as requested from the licensee via email and verbal. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730			

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0 730	Continued From page 36 (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional for four of five residents (R1, R8, R13, R14). 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:	0 730			

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0 730	Continued From page 37 The licensee had 15 residents receiving assisted living services. The following incident reports (IR) involved current residents receiving services from the assisted living provider: R1 R1's IR's included: - January 3, 2025, at 4:45 p.m., written by unlicensed personnel (ULP) indicated R1 had a fall outside front door, clinical nurse supervisor (CNS)-D notified. - November 29, 2024, at 1:00 p.m., written by ULP indicated fall in R1's room, nurse supervisor not notified. - November 26, 2024, at 8:00 p.m., written by ULP, indicated fall in R1's room, nurse/supervisor notified. - November 24, 2024, at 1:15 p.m., written by ULP, indicated fall in R1's room, nurse/supervisor notified. - November 16, 2024, at 12:45 p.m., written by ULP, indicated fall in R1's room, registered nurse (RN)-J notified. - November 3, 2024, at 7:30 p.m., written by ULP, indicated R1 had seizure, CNS-D notified. - October 10, 2024, at 5:00 p.m., written by ULP, indicated fall in R1's room, CNS-D notified. R8 R8's IR's included: - December 27, 2024, at 12:30 a.m., written by ULP, indicated maltreatment suspected due to rash on buttock, manager (M)-C notified. - November 8, 2024, at 8:27 p.m., written by ULP, indicated skin breakdown, CNS-D notified. - October 24, 2024, at 7:30 a.m., written by ULP, indicated skin breakdown, CNS-D notified.	0 730			

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0 730	Continued From page 38 R13 R13's IR included: - January 1, 2025, at 1:30 a.m., written by ULP, indicated near-miss incident, no further information on report. R14 R14's IR's included: - November 4, 2024, at 9:20 p.m., written by ULP, indicated skin breakdown, CNS-D notified. - October 24, 2024, at 7:00 a.m., written by ULP, indicated fall in main bathroom, RN notified. R1, R8, R13, and R14 incident reports lacked a review by a RN or supervisor and lacked actions in response to the needs of the residents. On February 5, 2025, at 11:45 a.m., CNS-D stated staff would start the incident report and the RN would complete the report within twenty-four hours. CNS-D stated the RN would assess the situation, and add interventions to the care plan as needed. CNS-B was not sure why these incident reports were not completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	0 775			

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0 775	Continued From page 39 Based on observation, interview, and record review, the licensee failed to comply with Minnesota State Fire Code, under Minnesota Rules Chapter 7511. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 3, 2025, the facility floor plan was emailed by the owner (O)-B to the surveyor. On February 3, 2025, at 11:15 a.m., the surveyor toured the facility with manager (M)-C. During the tour, the surveyor observed the following: Obstructed Egress: 1. Illuminated exit signs were installed above two doors in the addition, that led out to an exterior patio, enclosed by a fence. Paths from these exit doors to the public right of way were not maintained free of snow. 2. An illuminated exit sign was installed above the door in the office that led out to the exterior of the facility. A path from this exit to the public right of way was not maintained free of snow. Additionally, plastic film taped along the door frame was installed over this door. 3. The floor plan labeled five fire exit doors leading to the exterior of the facility enclosed by a fence. - Two fence gates were installed leading out to the main parking area in front of the facility. The	0 775			

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0 775	Continued From page 40 hardware for opening and latching these gates was installed on the exterior side of the gates. Both gates had two gravity self-latching gate locks installed that required opening both latches simultaneously to open the gate. Additionally, there was a chain with a swivel eye bolt snap installed at each of these gates. - A third gate was installed leading out to a parking area on the west side of the building. This gate had a magnetic lock with a keypad installed on the exterior side of the gate. During the tour interview, M-C stated a solar panel provided power to this lock and it could be operated by using a remote stored inside the assisted living facility or the keypad. M-C stated the magnetic lock was not currently being used and explained that the gate could be opened by unlatching hardware on the exterior side of the gate. There was a drop rod gate latch at the base and a hook latch installed on the exterior side of the gate. 4. An illuminated exit sign was installed above the door leading into the employee office. A keyed lock was installed on the employee office door handle. 5. An illuminated exit sign was installed above the door leading into resident room 10/11. The interior side of this door had a lock installed on the door handle. 6. An illuminated exit sign was installed above the door that led out to the back patio from resident room 10/11. This illuminated exit sign had been installed backward and was not visible to the occupants in this room. 7. The floor plan labeled the living room door as a fire exit. Furniture was stored in front of this door obstructing access. 8. The floor plan labeled the door between the kitchen and dining area as a fire exit. A refrigerator, cleaning supplies, and a storage cart were stored in front of this door obstructing	0 775			

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0 775	Continued From page 41 access. A sliding bolt barrel lock was installed at the top of the door. A path from this exit door to the public right of way was not maintained free of snow. 9. The floor plan labeled the main entrance door as a fire exit. A sliding bolt barrel lock was installed at the top of this door. 10. The floor plan labeled the dining room door as a fire exit. Half of a sliding bolt barrel lock was installed at the top of this door. A path from this exit door to the public right of way was not maintained free of snow. 11. A porch swing was installed on the exterior of the facility obstructing the egress window for occupied resident room 3/4. 12. The floor plan labeled the big brown shed (house) as a location for evacuation safety. A lock was installed on the brown shed door that would be used to enter this building from the assisted living facility. During an interview on February 3, 2025, at approximately 2:45 p.m., O-B stated the brown shed was used to access the public right of way in the event of an evacuation and that the fence gates were not used. The path used for egress escape cannot go into another building to access the public right of way. All paths of egress must provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency. A means of egress shall be free from obstructions that would prevent its use. Fire Hazards: 13. Outside the main entrance on the patio, an open shallow ashtray containing burnt cigarettes was stored on top of a wood table. Cigarette ashes were observed on top of the wood table and inside a broken bowl stored on top of this table. In the back patio area, burnt cigarettes	0 775			

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NAME OF PROVIDER OR SUPPLIER A DAUGHTERS LOVE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 25184 THUNDER ROAD STAPLES, MN 56479		
(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
0 775	Continued From page 42 were disposed of in an open shallow ashtray stored on top of a table. Burnt cigarettes had also been disposed of inside an open metal bucket stored alongside the wood fence. Improper smoking material disposal creates a fire hazard. 14. Electric wall heaters were installed in the employee office and inside resident rooms 10/11 and 12. There were caution labels on the heaters instructing the user that combustibles must be stored at least 3 feet from the front of the heater. In occupied resident room 12, a free-standing electric fireplace was stored less than 3 feet away from the front of this wall heater. Additionally, a box of gloves and an aerosol can of air freshener were stored on top of the electric fireplace. During the tour, M-C pushed the electric fireplace to the side. On February 6, 2025, at 12:30 p.m., the surveyor toured the facility with M-C. During the tour, the surveyor observed the following: - In the employee office, the wall heater was on and observed to be hot on the surface. A desk with stacks of papers was located in front of the heater. Additionally, items were stored under the desk on the floor directly in front of the heater. M-C turned the heater off and relocated the items stored under the desk during the facility tour. - In occupied resident room 12, a free-standing electric fireplace was stored less than 3 feet away from the front of the wall heater. Additionally, an aerosol can of air freshener was stored on top of the electric fireplace. During the tour, M-C stated someone must have slid the electric fireplace back in front of the wall heater. M-C pushed the electric fireplace to the side. - In occupied resident room 10/11, a lift was stored approximately 2 feet in front of a wall heater. During the tour, M-C pushed the lift until it was more than 3 feet away from the front of the wall heater. 15. In resident room 3/4, an extension cord was	0 775			

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0 775	Continued From page 43 used to supply power. Carbon Monoxide Alarms: 16. Carbon monoxide alarms were not installed within ten feet of occupied resident sleeping rooms 3/4 and 5. When carbon monoxide alarms are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms. Oxygen Storage: 17. In occupied resident room 7/8, two oxygen cylinders were stored inside the closet. One of these oxygen cylinders was not stored in a rack or cart to prevent the cylinder from falling over. During the tour interview, M-C verified the above listed observations. Emergency Lights and Exit Signs: 18. On February 6, 2025, at 12:30 p.m., the surveyor toured the facility with manager (M)-C. During the tour, the surveyor requested records for the inspection and testing of the illuminated exit signs and emergency lights completed in the last year. During the tour interview, M-C stated they did not know if these inspections and tests were completed and the surveyor should check with the owner. On February 6, 2025, at 4:13 p.m., the surveyor emailed O-B requesting records for the inspection and testing of the illuminated exit signs and emergency lights completed in the last year. On February 10, 2025, at 9:20 a.m., O-B emailed the surveyor and responded the inspections and tests were missed and they were planning to hire a professional so this would be completed correctly. No inspection or testing records were provided.	0 775			

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0 775	Continued From page 44	0 775			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect more than a limited number of residents, staff, and visitors.	0 780			

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0 780	Continued From page 45 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 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: On February 3, 2025, at 11:15 a.m., the surveyor toured the facility with manager (M)-C. During the tour, the surveyor observed the following: 1. In occupied resident sleeping room 5, the date on the back of the smoke alarm was 1998. Smoke alarms must be replaced every 10 years, or as recommended by the manufacturer. 2. When dwelling unit smoke alarms were tested, the smoke alarm installed outside of occupied resident sleeping rooms 1/2 was not activated. During the tour interview, M-C verified the above listed observations. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and	0 790			

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0 790	Continued From page 46 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain portable fire extinguishers as required by statute. This deficient condition 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 3, 2025, at 11:15 a.m., the surveyor toured the facility with manager (M)-C. During the tour, the surveyor observed the following: 1. In the activity room, the fire extinguisher cabinet was obstructed by a table and potted plant stored in front of the cabinet. 2. There was a 1-A:10-B:C rated fire extinguisher stored on the floor under an activity room table. During the tour interview, M-C stated this was an extra fire extinguisher and was not aware it was located here. 3. A fire extinguisher was mounted inside the kitchen pantry cabinet. The location of the fire extinguisher was not identified with a sign. Fire extinguishers must be available in an emergency and properly installed.	0 790			

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0 790	Continued From page 47 4. An annual maintenance tags was not attached to the fire extinguisher installed in the kitchen pantry cabinet. The annual maintenance tag attached to the fire extinguisher stored on the floor under the activity room table was dated 2023. Annual maintenance performed by certified service personnel is required every year. 5. The surveyor requested monthly fire extinguisher inspection records for 2024. M-C stated these records were not available and would need to be requested from maintenance. No further information was provided. Fire extinguisher inspections must be completed and recorded every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the tour interview, M-C verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800			

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0 800	Continued From page 48 by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 3, 2025, at 11:15 a.m., the surveyor toured the facility with manager (M)-C. During the tour, the surveyor observed the following: 1. In the shared resident bathroom on the north side of the building, base trim was missing, one of the entry doors was catching on the floor preventing the door from opening fully, unfinished walls were chipped and patched, the floor surface was peeling in the shower, grout was missing from the tile floor in front of the toilet, the cover for the ceiling light fixture was missing, floor tile was chipped, one light bulb was not working above the sink vanity, and the mirror in front of the sink vanity was not mounted on the wall. 2. The area around the junction box was cracked on the electric water heater in the mechanical closet. 3. Base trim was missing between the floor/wall junction in the living room on the north side of the building and in occupied resident room 2/3. 4. In occupied resident room 10/11, there were	0 800			

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0 800	Continued From page 49 holes in the door, trim was missing around the double set of exterior doors, and part of the closet frame was detached. 5. In occupied resident room 12, there were holes in the wall behind the door. In occupied resident room 7/8, there were holes in the wall behind the chair. 6. One exterior electrical wall outlet cover was broken. 7. One of the clothes washing machines was broken. During the facility tour interview, M-C stated a new machine was on order and that there was a second laundry room with a washing machine available. During the tour interview, M-C verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff of assisted living facilities shall receive	0 810			

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0 810	Continued From page 50 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 staff 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 develop the fire safety and evacuation plan with required content, make the plan readily available, and provide required training and drills. 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) 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 February 3, 2025, manager (M-)C and owner (O)-B provided documents on the fire safety and	0 810			

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0 810	Continued From page 51 evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN On February 3, 2025, at 11:15 a.m., the surveyor toured the facility with M-C. During the tour, the surveyor observed the following: 1. Page one of the ADL Safety and Security dated December 10, 2020, and August 3, 2022, was tacked and taped to the wall behind jackets that were hung up on the wall near the main entrance door. The ADL Safety and Security document indicated it was a policy for staff to follow in case of a fire. The fire safety and evacuation (FSEP) floor plan was not posted at the main entrance. The fire safety and evacuation plan (FSEP) was not located in a central location for all staff accessibility. 2. On February 3, 2025, an updated facility floor plan was emailed by O-B to the surveyor. This FSEP floor plan failed to include the location and/or number of resident sleeping rooms evident by the lack of resident sleeping rooms labels. During the tour, the floor plan posted in the dining room failed to include the location and/or number of resident sleeping rooms evident by the lack of resident sleeping room labels. Resident sleeping room identifiers are required to be included on the fire safety and evacuation floor plan and used with the identifiers installed on the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. 3. The FSEP floor plan was not drawn accurately to scale. The FSEP floor plan shall be easy to read and readily understandable by the building occupants in the event of an emergency. 4. M-C verbally identified resident sleeping rooms 3/4 and 9. The surveyor observed numbers were	0 810			

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0 810	Continued From page 52 not posted on or at the resident sleeping room doors. Resident sleeping room identifiers are required to be posted as part of the FSEP. 5. The number one was posted on a resident sleeping room door and M-C verbally identified this resident room as number one. The surveyor observed the FSEP floor plan posted inside this room labeled this sleeping room as 9. 6. M-C verbally identified resident sleeping room 9 and the surveyor observed the FSEP floor plan posted inside the room labeled this sleeping room as number one. The licensee failed to accurately identify resident sleeping rooms 1 and 9. 7. The FSEP floor plan labeled 5 fire exits and exit signs were not posted at these doors. During the tour interview on February 6, 2025, M-C verified exit signs were not posted at the doors labeled as exits on the FSEP floor plan. 8. Record review indicated the FSEP included a 3-page ADL Safety and Security document dated December 10, 2020, and August 3, 2022. The licensee FSEP was not developed and maintained relative to the facility's building layout and environmental risks. The FSEP instructed employees to confine the fire by closing doors. The FSEP indicated that closing doors also allows the sprinkler system (no sprinkler system) to be more effective at extinguishing a fire. The FSEP indicated fire doors create a safe barrier on the opposite side of the fire to "stage" residents in a safe area while evacuating the smoke compartment where the fire is located. (no fire doors on premise at this time). The FSEP inaccurately referenced smoke compartments, fire doors, and sprinklers in a building that did not have any fire resistant construction or life safety systems. 9. The FSEP floor plan inappropriately directs the building occupants to evacuate to the big brown	0 810			

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0 810	Continued From page 53 shed instead of to the public right of way. 10. The FSEP failed to identify fire protection procedures necessary for residents evident by a lack of these procedures in the plan. 11. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures in the plan. The FSEP shall be developed and maintained to provide efficient communication for exiting in the event of a fire or similar emergency. During an interview, on February 3, 2025, at 2:45 p.m., M-C and O-B verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by the lack of training documentation. A new hire training record dated April 7, 2023, was provided. No additional employee training records were provided. During an interview, on February 3, 2025, at 2:45 p.m., M-C and O-B verified the employee FSEP training frequency had not been completed as required by statute. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. No resident training records were provided for review. During an interview, on February 3, 2025, at 2:45 p.m., M-C and O-B verified resident training had not been completed as required by statute. DRILLS Record review indicated the licensee failed to	0 810			

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0 810	Continued From page 54 conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of employee sign in sheets. Record review indicated two drills were completed in 2024. These records were dated April 9, 2024, and October 8, 2024. The time or shift of these drills was not recorded. During an interview, on February 3, 2025, at 2:45 p.m., M-C and O-B verified the evacuation drill frequency was not met and the required documentation not recorded. M-C stated they thought the evacuation fire drill frequency was twice per year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to submit a Minnesota Department of Health Engineering Services plan review application and obtain a local permit for construction of a building addition. This had the potential to directly affect all residents, staff, and	0 830			

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NAME OF PROVIDER OR SUPPLIER A DAUGHTERS LOVE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 25184 THUNDER ROAD STAPLES, MN 56479		
(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
0 830	Continued From page 55 visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 3, 2025, at 11:15 a.m., the surveyor toured the facility with manager (M)-C. During the tour, the surveyor observed the following: 1. Occupied resident sleeping rooms 10/11 and 12 and an employee office were located in the part of the facility referred to as the addition. Inspection stickers on the electrical panels indicated electrical work was completed in the facility between August 2, 2021, and February 28, 2022. During the facility tour interview, M-C stated they did not know what year the addition was constructed. 2. On February 6, 2025, at 8:25 a.m., the surveyor emailed the owner (O)-B requesting copies of the building permit and certificate of occupancy for the addition. On February 6, 2025, at 9:16 a.m., O-B emailed they would check with the builders but they were pretty sure they did not have a permit as the facility is located in the county and not the city. O-B indicated that when they originally purchased the property, they did recall checking with both and were pretty certain they did not need a permit. 3. On February 6, 2025, at 4:13 p.m., the surveyor emailed O-B requesting the dates when the construction of the addition started and when the project was complete. On February 10, 2025,	0 830			

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0 830	Continued From page 56 at 9:20 p.m., O-B responded construction started in June 2021 and finished in September 2021, as that is when the last payment was made. Additionally the final electrical inspection from Department of Labor and Industry was completed on August 2, 2021. 4. The Department of Labor and Industry emailed the surveyor on February 12, 2025, and verified the property owner failed to obtain the required land use permits from Todd County for the building addition. A copy of the Conditional Use Permit (CUP) dated August 20, 2020, was attached to the email. The CUP indicated the proposed use allowed no more than 15 residents and an expansion beyond this number must be reviewed by the planning commission. The Minnesota Department of Health assisted living license indicated a current license capacity of 18 residents. The surveyor verified a Minnesota Department of Health Engineering Services plan review application had not been submitted for the building addition. New construction plans for work beginning on or after August 1, 2021, requires plan review by Minnesota Department of Health Engineering Services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830			
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of:	0 900			

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0 900	Continued From page 57 (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and execute a written contract, with the required content prior to providing assisted living services for two of three residents (R1, R2). 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	0 900			

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0 900	Continued From page 58 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: During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee was familiar with current minimum assisted living requirements. R1 R1 was admitted on February 25, 2019, and started receiving services under the assisted living license on August 1, 2021. R1's diagnoses included traumatic brain injury and left sided weakness. R1's service plan dated June 7, 2024, indicated R1 received medication administration, assistance with bathing, dressing, grooming, monthly vital signs, incontinence cares, brace/splint application and removal, high behavior management, smoking assistance, housekeeping, and laundry. On February 4, 2025, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-F and ULP-G perform morning cares for R1. On February 5, 2025, at 10:00 a.m., O-B stated via phone, O-B was unable to find R1's written contract. R2 R2 was admitted on December 27, 2023, and started to receive assisted living services.	0 900			

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0 900	Continued From page 59 R2's diagnosis included hypertension (high blood pressure), and diabetes. R2's Service Plan dated September 18, 2024, indicated R2 received medication administration, assistance with dressing, bathing, housekeeping, and laundry. On February 5, 2025, at 11:24 a.m., O-B stated via phone, O-B was unable to find R2's written contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for one of one resident (R4). This practice resulted in a level one violation (a	0 970			

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0 970	Continued From page 60 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R4 was admitted to the facility on April 20, 2021, and had begun receiving assisted living services on August 1, 2021. R4's Assisted Living Contract updated August 1, 2021, was signed by R4 and owner (O)-B on July 19, 2022. The licensee's Assisted Living Contract updated August 1, 2021, included the following clauses that a resident would waive the facility's liability for health, safety, or personal property of the resident: -page eight, Personal Property: You (resident) agree that Landlord [sic] is not responsible for any loss or damage to your personal property due to theft, or damage due to fire, water, tornado or other acts of nature beyond Landlord's [sic] control; and -page nine, Liability: Landlord is not liable to Tenant (resident) [sic] ... for any injury, death or property damage occurring in the Apartment [sic] or on Landlord's [sic] premises unless such injury, death or property damage occurs as a result of Landlord's [sic] own negligent acts or those of its employees or agents [sic]. Tenant (resident) agrees to hold Landlord [sic] harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment [sic] or on Landlord's	0 970			

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0 970	Continued From page 61 [sic] premises. On February 6, 2025, at 3:57 p.m., clinical nurse supervisor (CNS)-D stated the same assisted living contract was used for all residents. CNS-D further stated CNS-D did not think a waiver of liability was written into the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the	01060			

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01060	Continued From page 62 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative for one of one resident (R4) with an emergency relocation. 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:	01060			

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01060	Continued From page 63 During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee was familiar with current minimum assisted living requirements. R4's diagnosis included unspecified dementia with behavior disturbance. R4's Service Plan dated January 22, 2025, indicated R4 received medication administration, TEDS (compression stockings), monitoring vital signs, and assistance with bathing, grooming, dressing, and light housekeeping. On February 5, 2025, at 9:54 a.m., the surveyor observed unlicensed personnel (ULP)-F provide scheduled morning medication administration for R4. R4's Resident Notes-One Resident dated November 9, 2024, had a written entry which indicated the ULPs contacted clinical nurse supervisor (CNS)-D on November 9, 2024, at 1:00 a.m. regarding R4 was found of the floor at the foot of R8's bed. R4 had a laceration to lower left leg and "goose egg" to R4's head. R4 went to the ER (emergency room), had a CT (cat scan) of R4's head and spine. R4 received 12 sutures to R4's leg laceration. R4 returned to the facility with a diagnosis of fall, open wound of leg, and contusion of scalp. R4's son was upset due to not notified of the incident when it happened, and CNS-D apologized to R4's son. R4's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider;	01060			

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01060	Continued From page 64 - contact information for the Office of Ombudsman for Long Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On February 6, 2025, at 3:52 p.m., CNS-D stated CNS-D was not aware the requirement for resident emergency relocations and CNS-D had never completed an emergency relocation on any resident. CNS-D further stated CNS-D had never provided emergency relocation notice to the OOLTC if a resident was hospitalized for longer than four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01290 SS=I	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	01290			

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01290	Continued From page 65 section 13.02, subdivision 12. (c) Termination of a staff member 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 current employee records contained all the required content to include a current background study clearance letter for two of nine employees (unlicensed personnel (ULP)-H, ULP-I). This had the potential to affect all residents living within the facility. This resulted in an immediate correction order identified on February 5, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on February 5, 2025. During the entrance conference on February 3, 2025, owner (O)-B stated the licensee was aware of required contents in an employee record.	01290			

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01290	Continued From page 66 ULP-H ULP-H was hired on January 7, 2025, to provide direct care services to residents at the facility. The licensee's NETStudy 2.0 Roster with healthcare facility identification (HFID) 36902 printed on February 5, 2025, indicated ULP-H was not listed as a current employee. The licensee's weekly schedules indicated ULP-H worked 10:00 p.m. until 6:00 a.m., nine shifts out of 19 opportunities from January 12, 2025, until January 30, 2025. In addition, the weekly schedule indicated ULP-H was scheduled to work 10:00 p.m. until 6:00 a.m., the nights of February 4, 2025, February 6, 2025, February 7, 2025, February 8, 2025, and February 9, 2025, respectively. ULP-I ULP-I was hired on January 16, 2025, to provide direct care services to residents at the facility. The licensee's NETStudy 2.0 Roster with HFID 36902 printed February 5, 2025, indicated ULP-I's background study determination was in process, and that ULP-I required supervision. The licensee's weekly schedules indicated ULP-I trained with another ULP on January 21, 2025, and January 27, 2025, respectively. In addition, the weekly schedule indicated ULP-I was scheduled to work overnights as the second ULP on January 31, 2025, February 1, 2025, and February 2, 2025, respectively. On February 5, 2025, at 1:42 p.m. through 1:53 p.m., the surveyor reviewed the NETStudy 2.0 website and rosters with manager (M)-C. M-C stated O-B or assisted living director in residency	01290			

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01290	Continued From page 67 (ALDIR)-A were responsible to complete background studies on employees. M-C stated ULP-H was a current ULP whom worked overnight for the licensee as one of two ULPs scheduled for the night shifts. M-C searched ULP-H's last name and date of birth on the NETStudy 2.0 website, which resulted in two matches to ULP-H's name and date of birth. M-C clicked on each name match for ULP-H, however, the site indicated for each match ULP-H was no longer affiliated with licensee resulting in no background study for ULP-H under the licensee. M-C reviewed ULP-I's information on the NETStudy 2.0 roster, and stated ULP-I required supervision, however, ULP-I was still in training was always with the other night staff at all times, even though ULP-I was listed as the second ULP providing services to residents on the overnight shift. On February 5, 2025, at 2:05 p.m., ULP-G stated ULP-G had worked overnights for eight months upon hire, and when two ULPs were scheduled at night both ULPs provided independent resident cares unless a resident required assistance of two staff. On February 5, 2025, at 2:11 p.m., clinical nurse supervisor (CNS)-D stated CNS-D did not know if the two ULPs that work overnights were always together since CNS-D was not present on the overnight shifts, however, CNS-D stated ULPs were supposed to work as a team. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. In addition, if hired prior to	01290			

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01290	Continued From page 68 receiving the results of the background study, or the tentative background study results indicate more time is needed requiring supervision, new hires shall not be permitted to interact or provide services to tenants or clients of (licensee name) except under the direct supervision (eyesight) of another qualified staff person. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			

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01360	Continued From page 69	01360			
01360 SS=F	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. 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) provided training or the training was provided by another instructor in conjunction with a RN, and competency evaluations were completed by the RN for unlicensed personnel (ULP) providing assisted living services for two of two employees (ULP-F, ULP-G). 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 February 3,	01360			

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01360	Continued From page 70 2025, at 10:00 a.m., owner (O)-B stated upon hire ULPs completed online training, ULPs shadowed other ULPs, ULPs completed skills competency (O-B did not indicate with whom), and ULPs proceeded to work independently. ULP-F ULP-F was hired on August 30, 2024, to provide direct care services to residents at the facility. On February 5, 2025, at 9:54 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R4. ULP-F's employee record contained a New Hire Orientation Checklist dated August 30, 2024. On page four: section Skill Assessments with RN and section RN, indicated from August 30, 2024, through September 2, 2024, training was completed by manager (M)-C (not a RN) and the observation space was left blank. Page five of New Hire Orientation Checklist included signatures of ULP-F and M-C. Written directly below M-C's signature was "M-C housing manager reviewed all RN skills packet and RN signed packet on date that she (CNS-D) reviewed" signed by O-B, however, was not dated. O-B was also not a RN. Below the written statement was clinical nurse supervisor (CNS)-D's signature with no date. ULP-F's employee record contained a Skill Assessments form dated September 18, 2024, which indicated ULP-F had passed core competency testing and passed delegated treatment and task competencies. On page 31 the RN signature and date were left blank, however, a note was written "signed on back paper also med (medications) trained on two spots whole thing [sic]." RN-J signed page 32 on	01360			

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01360	Continued From page 71 September 18, 2024. ULP-F's employee record lacked sufficient evidence ULP-F was trained or trained by another instructor in conjunction with a RN, and the RN completed competency evaluations for ULP-F. On February 5, 2025, at 9:58 a.m., ULP-F stated ULP-F had been employed at the facility for four months. ULP-F further stated ULP-F was trained in and orientated to residents by other ULPs at the facility. ULP-F stated RN-J had watched ULP-F administer a "few" medications after ULP-F had passed resident medications with other ULPs without RN supervision or deemed competent by the RN. ULP-F further stated ULP-F completed the majority of ULP-F's training with ULP-E. ULP-G ULP-G was hired on November 27, 2023, to provide direct care services to residents at the facility. ULP-G's employee record contained a New Hire Orientation Checklist dated December 5, 2023. Pages one through five had arrows with lines documented in pink ink. On page four, section Skill Assessments with RN and section RN, indicated training and observations were completed by an employee with initials identified as a ULP. Next to the ULP's initials was written RN. Page five of New Hire Orientation Checklist included signatures of ULP-G in black ink and O-B's (not an RN) signature in pink ink. Written below O-B's signature was CNS-D's signature with the date of December 6, 2023, in black ink. ULP-G's employee record contained the following Knowledge Assessments dated December 1,	01360			

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01360	Continued From page 72 2023, signed only by O-B or M-C (neither RNs): -Emergency Preparedness Overview (questions were not answered); -Emergency Preparedness: Site and Natural Hazards (questions were not answered); -Emergency Preparedness: Human Hazards (questions were not answered); -Assisted Living Bill of Rights (questions were not answered); -Documenting, Observing, and Reporting; -Fall Prevention; -Aging Process; -Customer Service: from Ordinary to Extraordinary [sic]; -Personal Cares; -OSHA and Infection Control; -HIPPA (confidentiality); -Communication Overview; -Dementia Activities of Daily Living; -Problem Solving Overview; -Dementia Person Centered; -Communication-Family Support; -Problem Solving- Wandering and Elopement; -Problem Solving- Anger and Aggression; -Problem Solving- Anxiety; -Problem Solving- Rummaging and Hoarding; -Communication- Reality and Validation; -Overview- Alzheimer's Disease; -Activities- Dressing and Grooming; -Activities- Toileting; -Dementia Activities-Bathing; -Medication Administration and Medication Administration-Overview; -Residential Providers; -Dining, Nutrition, and Food Safety; -Vital Signs; -Client Mobility-Positioning; -Client Mobility- Range of Motion; -Client Mobility- Lifting and Safe Transfers; -Client Mobility- Exercise and Ambulation;	01360			

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01360	Continued From page 73 -Medicaid Fraud and Abuse (no employee name listed just date of December 1, 2023); -Wound Care; -Oxygen; and -O2 Sats (oxygen saturation). ULP-G's employee record contained a Skill Assessments form dated December 6, 2023, indicating ULP-G had passed competencies for core training and delegated treatments and tasks. Pages one through 30 of the Skill Assessments were stapled together, with an additional loose page 31 that followed which was not stapled to the packet, and did not have staple holes to indicate page 31 had been previously attached to the Skill Assessments. Page 31 did contain CNS-D's signature. ULP-G's employee record lacked sufficient evidence ULP-G was trained or trained by another instructor in conjunction with a RN, and the RN completed competency evaluations for ULP-G. On February 5, 2025, at 12:41 p.m., ULP-G stated ULP-G was trained and competency tested by M-C and other ULPs at the facility. ULP-G further stated ULP-G had not been trained or competency tested by an RN. ULP-G stated ULP-G was told to sign ULP-G's name on all the documentation upon hire even though training and competency testing had not been completed. On February 5, 2025, at 12:46 p.m., CNS-D stated the ULP's were trained by online training, then ULP's train the new ULP's while working the floor, and do a big skills packet. CNS-D stated then CNS-D would test them on the skills. Additionally, CNS-D stated M-C did the on-boarding, and went through new hire	01360			

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01360	Continued From page 74 orientation. On February 5, 2025, at 12:54 p.m., M-C stated M-C went over the training listed on ULP-F's orientation pages and stated that M-C was identified on ULP-F's orientation form as the trainer. On February 5, 2025, at 1:34 p.m., CNS-D stated CNS-D did not provide the initial training to ULPs, however, CNS-D watched ULPs complete all medication administration routes and delegated competencies "whether they (ULPs) know or not", and then CNS-D signed the competency forms. CNS-D further stated CNS-D was not sure why ULP-G's original Skill Assessment forms did not include CNS-D's original signature page. On February 6, 2025, at 9:52 a.m., RN-J returned the surveyor's phone call from February 5, 2025. RN-J stated RN-J had deemed ULP-F competent to complete medication administration to residents after ULP-F had trained on the floor with a "lead" ULP. RN-J stated RN-J observed one oral medication pass for a resident with ULP-F, however, RN-J did not observe ULP-F complete a blood glucose test or any other competencies. RN-J further stated RN-J was just helping out the licensee and had only been employed at the licensee for a short time. On February 6, 2025, at 3:34 p.m., M-C stated the licensee used the same training and competency process upon hire for all ULPs. On February 6, 2025, at 3:40 p.m., CNS-D stated we (the licensee) gave you (the surveyors) all the information the licensee had available for employee records.	01360			

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01360	Continued From page 75 The licensee's 5.02 Competency Training Evaluations policy dated July 1, 2021, indicated when a RN or licensed health professional staff delegates tasks, prior to the delegation of services they (RN or licensed health professional) must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each client (resident) and are able to demonstrate the ability to competently follow the procedures and perform the tasks [sic]. In addition, the RN will determine what nursing services may be delegated to properly trained and competency tested ULPs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01360			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting;	01370			

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01370	Continued From page 76 (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel ((ULP)-F, ULP-G) to include all required content. 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).	01370			

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01370	Continued From page 77 The findings include: During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee was aware of required contents in an employee record. O-B further stated upon hire ULPs completed online training, ULPs shadowed other ULPs, ULPs completed skills competency (O-B did not indicate with whom), and ULPs proceeded to work independently. ULP-F ULP-F was hired on August 30, 2024, to provide direct care services to residents at the facility. On February 5, 2025, at 9:54 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R4. ULP-F's employee record contained a New Hire Orientation Checklist dated August 30, 2024. On page four: section Skill Assessments with RN (registered nurse) and section RN, indicated from August 30, 2024, through September 2, 2024, indicated training was completed by manager (M)-C (not a RN) and the observation space was left blank. Page five of New Hire Orientation Checklist included signatures of ULP-F and M-C. Written directly below M-C's signature was "M-C housing manager reviewed all RN skills packet and RN signed packet on date that she (CNS-D) reviewed" signed by O-B, however, was not dated. O-B was also not a RN. Below the written statement was clinical nurse supervisor (CNS)-D's signature with no date. ULP-F's employee record contained a Skill Assessments form dated September 18, 2024, which indicated ULP-F had passed core competency testing and passed delegated	01370			

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01370	Continued From page 78 treatment and task competencies. On page 31 the RN signature and date were left blank, however, a note was written "signed on back paper also med (medications) trained on two spots whole thing [sic]." RN-J signed page 32 on September 18, 2024. ULP-F's employee record lacked sufficient evidence of documentation of training by the RN or in conjunction with the RN, and competency evaluations, if applicable, by the RN for the following: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aides; -dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -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; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and	01370			

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01370	Continued From page 79 -awareness of commonly used health technology equipment and assistive devices. On February 5, 2025, at 9:58 a.m., ULP-F stated ULP-F had been employed at the facility for four months. ULP-F further stated ULP-F was trained in and orientated to residents by other ULPs at the facility. ULP-F stated registered nurse (RN)-J had watched ULP-F administer a "few" medications after ULP-F had passed resident medications with other ULPs without RN supervision or deemed competent by the RN. ULP-F further stated ULP-F completed the majority of ULP-F's training with ULP-E. ULP-G ULP-G was hired on November 27, 2023, to provide direct care services to residents at the facility. ULP-G's employee record contained a New Hire Orientation Checklist dated December 5, 2023. Pages one through five had arrows with lines documented in pink ink. On page four, section Skill Assessments with RN and section RN, indicated training and observations were completed by an employee with initials identified as a ULP. Next to the ULP's initials was written RN. Page five of New Hire Orientation Checklist included signatures of ULP-G in black ink and O-B's (not an RN) signature in pink ink. Written below O-B's signature was CNS-D's signature with the date of December 6, 2023, in black ink. ULP-G's employee record contained the following Knowledge Assessments dated December 1, 2023, signed only by O-B or M-C (neither RNs): -Emergency Preparedness Overview (questions were not answered); -Emergency Preparedness: Site and Natural	01370			

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01370	Continued From page 80 Hazards (questions were not answered); -Emergency Preparedness: Human Hazards (questions were not answered); -Assisted Living Bill of Rights (questions were not answered); -Fall Prevention; -Aging Process; -Customer Service: from Ordinary to Extraordinary [sic]; -Personal Cares; -OSHA and Infection Control; -HIPPA (confidentiality); -Communication Overview; -Dementia Activities of Daily Living; -Problem Solving Overview; -Dementia Person Centered; -Communication-Family Support; -Problem Solving- Wandering and Elopement; -Problem Solving- Anger and Aggression; -Problem Solving- Anxiety; -Problem Solving- Rummaging and Hoarding; -Communication- Reality and Validation; -Overview- Alzheimer's Disease; -Activities- Dressing and Grooming; -Activities- Toileting; -Dementia Activities-Bathing; -Residential Providers; -Dining, Nutrition, and Food Safety; -Client Mobility- Lifting and Safe Transfers; -Client Mobility- Exercise and Ambulation; and -Medicaid Fraud and Abuse (no employee name listed just date of December 1, 2023); ULP-G's employee record contained a Skill Assessments form dated December 6, 2023, indicating ULP-G had passed competencies for core training and delegated treatments and tasks. Pages one through 30 of the Skill Assessments were stapled together, with an additional loose page 31 that followed which was not stapled to	01370			

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01370	Continued From page 81 the packet, and did not have staple holes to indicate page 31 had been previously attached to the Skill Assessments. Page 31 did contain CNS-D's signature. ULP-G's employee record lacked sufficient evidence of documentation of training by the RN or in conjunction with the RN, and competency evaluations, if applicable, by the RN for the following: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aides; -dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -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; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices.	01370			

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NAME OF PROVIDER OR SUPPLIER A DAUGHTERS LOVE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 25184 THUNDER ROAD STAPLES, MN 56479		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01370	Continued From page 82 On February 5, 2025, at 12:41 p.m., ULP-G stated ULP-G was trained and competency tested by M-C and other ULPs at the facility. ULP-G further stated ULP-G had not been trained or competency tested by an RN. ULP-G stated ULP-G was told to sign ULP-G's name on all the documentation upon hire even though training and competency testing had not been completed. On February 5, 2025, at 12:46 p.m., CNS-D stated the ULP's are trained by online training, then ULP's train the new ULP's while working the floor, and do a big skills packet. CNS-D stated then CNS-D would test them on the skills. Additionally, CNS-D stated M-C did the on-boarding, and went through new hire orientation. On February 5, 2025, at 12:54 p.m., M-C stated M-C went over the training listed on ULP-F's orientation pages and stated that M-C was identified on ULP-F's orientation form as the trainer. On February 5, 2025, at 1:34 p.m., CNS-D stated CNS-D did not provide the initial training to ULPs, however, CNS-D watched ULPs complete all medication administration routes and delegated competencies "whether they (ULPs) know or not", and then CNS-D signed the competency forms. CNS-D further stated CNS-D was not sure why ULP-G's original Skill Assessment forms did not include CNS-D's original signature page. On February 6, 2025, at 9:52 a.m., RN-J returned the surveyor's phone call from February 5, 2025. RN-J stated RN-J had deemed ULP-F competent to complete medication administration to residents after ULP-F had trained on the floor	01370			

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01370	Continued From page 83 with a "lead" ULP. RN-J stated RN-J observed one oral medication pass for a resident with ULP-F, however, RN-J did not observe ULP-F complete a blood glucose test or any other competencies. RN-J further stated RN-J was just helping out the licensee and had only been employed at the licensee for a short time. On February 6, 2025, at 3:34 p.m., M-C stated the licensee used the same training and competency process upon hire for all ULPs. On February 6, 2025, at 3:40 p.m., CNS-D stated we (the licensee) gave you (the surveyors) all the information the licensee had available for employee records. The licensee's 5.02 Competency Training Evaluations policy dated July 1, 2021, indicated when a RN or licensed health professional staff delegates tasks, prior to the delegation of services they (RN or licensed health professional) must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each client (resident) and are able to demonstrate the ability to competently follow the procedures and perform the tasks [sic]. The policy addressed all training and competency evaluation topics noted above. The policy addressed all training and competency evaluation topics noted above. In addition, a copy of all education, training, and competency testing shall be kept in each employee's personnel file. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each	01370			

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01370	Continued From page 84 competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	01380			

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01380	Continued From page 85 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 was completed for two of two unlicensed personnel ((ULP)-F, ULP-G) to include all required content. 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: During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee was aware of required contents in an employee record. O-B further stated upon hire ULPs completed online training, ULPs shadowed other ULPs, ULPs completed skills competency (O-B did not indicate with whom), and ULPs proceeded to work independently. ULP-F	01380			

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01380	Continued From page 86 ULP-F was hired on August 30, 2024, to provide direct care services to residents at the facility. On February 5, 2025, at 9:58 a.m., ULP-F stated ULP-F had been employed at the facility for four months. ULP-F further stated ULP-F was trained in and orientated to residents by other ULPs at the facility. ULP-F stated registered nurse (RN)-J had watched ULP-F administer a "few" medications after ULP-F had passed resident medications with other ULPs without registered nurse (RN) supervision or deemed competent by the RN. ULP-F further stated ULP-F completed the majority of ULP-F's training with ULP-E. On February 5, 2025, at 9:54 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R4. ULP-F's employee record contained a New Hire Orientation Checklist dated August 30, 2024. On page four: section Skill Assessments with RN and section RN, indicated from August 30, 2024, through September 2, 2024, indicated training was completed by manager (M)-C (not a RN) and the observation space was left blank. Page five of New Hire Orientation Checklist included signatures of ULP-F and M-C. Written directly below M-C's signature was "M-C housing manager reviewed all RN skills packet and RN signed packet on date that she (CNS-D) reviewed" signed by O-B, however, was not dated. O-B was also not a RN. Below the written statement was clinical nurse supervisor (CNS)-D's signature with no date. ULP-F's employee record contained a Skill Assessments form dated September 18, 2024, which indicated ULP-F had passed core competency testing, passed delegated	01380			

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01380	Continued From page 87 medication administration, and passed treatment administration competencies. On page 31 the RN signature and date were left blank, however, a note was written "signed on back paper also med (medications) trained on two spots whole thing [sic]." RN-J signed page 32 on September 18, 2024. ULP-F's employee record lacked sufficient evidence of documentation of training by the RN or in conjunction with the RN, and competency evaluations, if applicable, by the RN for the following: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications; and - administering treatments for glucometers, TEDS (compression stockings), oxygen administration, splints/braces, foley catheter care, wound care, dressing changes, and use of alarms. ULP-G ULP-G was hired on November 27, 2023, to provide direct care services to residents at the facility. On February 5, 2025, at 12:41 p.m., ULP-G stated ULP-G was trained and competency tested by M-C and other ULPs at the facility. ULP-G further stated ULP-G had not been trained or	01380			

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01380	Continued From page 88 competency tested by an RN. ULP-G stated ULP-G was told to sign ULP-G's name on all the documentation upon hire even though training and competency testing had not been completed. ULP-G's employee record contained a New Hire Orientation Checklist dated December 5, 2023. Pages one through five had arrows with lines documented in pink ink. On page four, section Skill Assessments with RN and section RN, indicated training and observations were completed by an employee with initials identified as a ULP. Next to the ULP's initials was written RN. Page five of New Hire Orientation Checklist included signatures of ULP-G in black ink and O-B's (not an RN) signature in pink ink. Written below O-B's signature was CNS-D's signature with the date of December 6, 2023, in black ink. ULP-G's employee record contained the following Knowledge Assessments dated December 1, 2023, signed only by O-B or M-C (neither RNs): - Medication Administration and Medication Administration-Overview; - Vital Signs; - Client Mobility-Positioning; - Client Mobility- Range of Motion; - Client Mobility- Lifting and Safe Transfers; - Client Mobility- Exercise and Ambulation; - Wound Care; - Oxygen; and - O2 Sats (oxygen saturation). ULP-G's employee record contained a Skill Assessments form dated December 6, 2023, indicating ULP-G had passed competencies for core training, passed medication administration, and passed delegated treatments. Pages one through 30 of the Skill Assessments were stapled together, with an additional loose page 31 that	01380			

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01380	Continued From page 89 followed which was not stapled to the packet, and did not have staple holes to indicate page 31 had been previously attached to the Skill Assessments. Page 31 did contain CNS-D's signature. ULP-G's employee record lacked sufficient evidence of documentation of training by the RN or in conjunction with the RN, and competency evaluations, if applicable, by the RN for the following: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications; and - administering treatments for glucometers, TEDS (compression stockings), oxygen administration, splints/braces, foley catheter care, wound care, dressing changes, and use of alarms. On February 5, 2025, at 12:46 p.m., CNS-D stated the ULP's are trained by online training, then ULP's train the new ULP's while working the floor, and do a big skills packet. CNS-D stated then CNS-D would test them on the skills. Additionally, CNS-D stated M-C did the on-boarding, and went through new hire orientation. On February 5, 2025, at 12:54 p.m., M-C stated M-C went over the training listed on ULP-F's	01380			

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01380	Continued From page 90 orientation pages and stated that M-C was identified on ULP-F's orientation form as the trainer. On February 5, 2025, at 1:34 p.m., CNS-D stated CNS-D did not provide the initial training to ULPs, however, CNS-D watched ULPs complete all medication administration routes and delegated competencies "whether they (ULPs) know or not", and then CNS-D signed the competency forms. CNS-D further stated CNS-D was not sure why ULP-G's original Skill Assessment forms did not include CNS-D's original signature page. On February 6, 2025, at 9:52 a.m., RN-J returned the surveyor's phone call from February 5, 2025. RN-J stated RN-J had deemed ULP-F competent to complete medication administration to residents after ULP-F had trained on the floor with a "lead" ULP. RN-J stated RN-J observed one oral medication pass for a resident with ULP-F, however, RN-J did not observe ULP-F complete a blood glucose test or any other competencies. RN-J further stated RN-J was just helping out the licensee and had only been employed at the licensee for a short time. On February 6, 2025, at 3:34 p.m., M-C stated the licensee used the same training and competency process upon hire for all ULPs. On February 6, 2025, at 3:40 p.m., CNS-D stated we (the licensee) gave you (the surveyors) all the information the licensee had available for employee records. The licensee's 5.02 Competency Training Evaluations policy dated July 1, 2021, indicated when a RN or licensed health professional staff delegates tasks, prior to the delegation of	01380			

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01380	Continued From page 91 services they (RN or licensed health professional) must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each client (resident) and are able to demonstrate the ability to competently follow the procedures and perform the tasks [sic]. The policy addressed all training and competency evaluation topics noted above. In addition, a copy of all education, training, and competency testing shall be kept in each employee's personnel file. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation.	01380			

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01380	Continued From page 92 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without	01460			

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01460	Continued From page 93 satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for one of one employee (unlicensed personnel (ULP)-F). 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 February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee was aware of required contents in an employee record. ULP-F was hired on August 30, 2024, to provide direct care services to residents at the facility. On February 5, 2025, at 9:54 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R4. ULP-F's employee record contained a New Hire Orientation Checklist dated August 30, 2024. On page two indicated electronic education assigned and password given to employee dated	01460			

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01460	Continued From page 94 September 2, 2024, by manager (M)-C. Listed directly below the electronic education assigned and password, had written "Electronic education printed and placed in employee file," however, the date was scribbled out and not legible. ULP-F's employee record lacked documentation to indicate ULP-F completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. On February 5, 2025, at 9:58 a.m., ULP-F stated ULP-F had been employed at the facility for four months. ULP-F further stated ULP-F was trained in and orientated to residents by other ULPs at the facility. ULP-F further stated ULP-F completed the majority of ULP-F's training with ULP-E. On February 6, 2025, at 3:34 p.m., M-C stated the licensee used the same hire process for all employees. M-C further stated the licensee had switched online training platforms and M-C may have missed assigning some orientation to assisted living trainings to ULP-F. On February 6, 2025, at 3:40 p.m., clinical nurse supervisor (CNS)-D stated we (the licensee) gave you (the surveyors) all the information the licensee had available for employee records. The licensee's 5.01 Orientation of Staff and Supervisors and Content [sic] policy dated August 1, 2022, indicated all staff of (licensee's name) providing and supervising direct services must complete an orientation to Assisted Living [sic] facility licensing requirements and regulations before providing assisted living services to residents.	01460			

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01460	Continued From page 95 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and	01500			

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01500	Continued From page 96 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the 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 an employee received all the required annual training content for each 12 months of employment for one of one employee (clinical nurse supervisor (CNS)-D). In addition, the licensee failed to ensure at least eight hours of annual training for each 12 months of employment for one of one employee (CNS-D). 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	01500			

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01500	Continued From page 97 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 February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee was aware of required contents in an employee record. CNS-D was hired on October 19, 2020, and had begun to provide direct care services to residents at the facility along with supervision of staff employed at the facility effective August 1, 2021. During the survey on February 5, 2025, through February 6, 2025, the surveyor observed CNS-D provide direct care services and interacted with residents at the facility. CNS-D's employee record contained an Annual Staff Performance Review dated October 11, 2024, which had written "Reviewed all P&P (policies and procedures) as well as yearly Educare (online training platform) classes," however, CNS-D's employee record lacked any further documentation of annual training. CNS-D's employee record lacked sufficient documentation for required annual training topics: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control	01500			

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01500	Continued From page 98 standards including a review of hand washing techniques; the need for and use of protective glove, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades, disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to sue to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. In addition, CNS-D's employee record indicated CNS-D had completed zero hours of annual training for each 12 months of employment for 2022, 2023, and 2024. On February 6, 2025, at 3:37 p.m., manager (M)-C stated the licensee provided annual training, however, was in the process of switching online training platforms, and would need to "push out" required annual training using the new online training platform to all employees. On February 6, 2025, at 3:40 p.m., CNS-D stated we (the licensee) gave you (the surveyors) all the information the licensee had available for employee records. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2022, indicated all staff that perform direct care services at (licensee's name) will complete at least eight (8) hours of annual training for each 12 months of employment. In addition, the policy included	01500			

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01500	Continued From page 99 required annual training for the above noted topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced	01530			

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01530	Continued From page 100 by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP-F)) received the required amount of dementia care training in the required time frame. In addition, the licensee failed to ensure one of one employee (clinical nurse supervisor (CNS)-D) received at least two hours of dementia care training for each 12 months of employment. 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: During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee was aware of required contents in an employee record. INITIAL DEMENTIA TRAINING ULP-F was hired on August 30, 2024, to provide direct care services to residents at the facility. On February 5, 2025, at 9:54 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R4. ULP-F's employee record contained a New Hire Orientation Checklist dated August 30, 2024. On page two had written "8 (eight) hours dementia training complete and in employee file." The date of completion was left blank.	01530			

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01530	Continued From page 101 The licensee's Weekly Schedules dated December 30, 2024, through February 2, 2025, indicated ULP-F was scheduled to work 161.75 hours. ULP-F's employee record lacked eight hours of dementia training within 160 hours of the employee start date for direct care employees. On February 5, 2025, at 9:58 a.m., ULP-F stated ULP-F had been employed at the facility for four months. ULP-F further stated ULP-F was trained in and orientated to residents by other ULPs at the facility. ULP-F further stated ULP-F completed the majority of ULP-F's training with ULP-E. ANNUAL DEMENTIA TRAINING CNS-D was hired on October 19, 2020, and had begun to provide direct care services to residents at the facility along with supervision of staff employed at the facility effective August 1, 2021. During the survey on February 5, 2025, through February 6, 2025, the surveyor observed CNS-D provide direct care services and interacted with residents at the facility. CNS-D's employee record contained an Annual Staff Performance Review dated October 11, 2024, which had written "Reviewed all P&P (policies and procedures) as well as yearly Educare (online training platform) classes." CNS-D's employee record lacked two hours of annual dementia training for 2022, 2023, and 2024. On February 6, 2025, at 3:34 p.m., manager	01530			

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01530	Continued From page 102 (M)-C stated the licensee used the same hire process for all employees. M-C stated the licensee had switched online training platforms and M-C probably missed assigning all dementia trainings for ULP-F. M-C further stated the licensee had hospice come in to provide some dementia, however, M-C did not provide records of the dementia trainings. On February 6, 2025, at 3:37 p.m., M-C stated the licensee provided annual training, however, was in the process of switching online training platforms, and would need to "push out" required annual training using the new online training platform to all employees. On February 6, 2025, at 3:40 p.m., CNS-D stated we (the licensee) gave you (the surveyors) all the information the licensee had available for employee records. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. In addition, all staff will complete two (2) hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=I	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 103 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: This correction order was modified on February 18, 2025, to add additional information regarding R2, R4, and R5. In addition, the scope was changed to widespread (I). Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment with a change in condition and failed to ensure 90-day comprehensive assessments did not exceed 90 days for four of four residents (R1, R2, R4, R5). This resulted in an immediate correction order identified on February 4, 2025.	01620			

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01620	Continued From page 104 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included traumatic brain injury and left sided weakness. R1's service plan dated June 7, 2024, indicated R1 received medication administration, assistance with bathing, dressing, grooming, monthly vitals, incontinence cares, brace/splint application and removal, high behavior management, smoking assistance, housekeeping and laundry. R1's invoice dated June 1, 2024, indicated R1 received: - high behavior management [elopement risk, wandering, repetitive redirection needed, orientation issues, combative, resistance to help, yelling, swearing, any verbal or physical aggression, increased safety checks] (normal is 1 per 8-hour shift); and -smoking assistance (assist resident or client in and out of the home as well as handling of lighter and cigarettes). On February 4, 2025, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-F and ULP-G perform morning cares for R1. The surveyor observed on R1's right hand, a bandage	01620			

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01620	Continued From page 105 on his fourth digit and black areas of skin on the tips of second and third fingers and various other blackened areas from the second knuckle to the tip of his finger, and R1's left hand had a bandage on his third digit. ULP-F and ULP-G stated it was frostbite from when it was 45 degrees below zero degrees Fahrenheit (F). ULP-G stated R1 was a smoker and thought it was from him being outside and smoking. ULP-F stated it was a couple of weeks ago, she was working with ULP-E and noticed blisters and discoloration on R1's fingers one morning, around January 19th she thought. ULP-F stated clinical nurse supervisor (CNS)-D was called and the ULPs sent pictures of R1's fingers as they thought it was frostbite. CNS-D told the ULPs she was sending the picture to the provider. ULP-F and ULP-G stated the fingers continued to turn blue, and get darker and darker, as the days went by. ULP-F and ULP-G stated they reached out to CNS-D again the next day but she still did not come in to assess R1's hands. On February 4, 2025, from 8:15 a.m. to 8:40 a.m., the surveyor interviewed CNS-D via phone. CNS-D stated she was notified of blisters on R1's hands on January 19, 2025, and did not assess R1 until January 21, 2025, however she stated she was conversing with the provider and staff through pictures on the phone that were being sent to her. CNS-D did not recall if she filled out an incident report, she wrote progress notes only, and stated she may not have his notes updated. R1's progress notes indicated the following: - January 19, 2025, at 1:19 p.m., written by CNS-D indicated staff called stating R1's fingers to the right hand was red, swollen and had blisters. Unknown cause. Resident smokes outside and the temperature was extremely cold.	01620			

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01620	Continued From page 106 Resident also has a heater in his room. Message sent to provider. Provider ordered to cleanse blisters with normal saline, apply Bacitracin and band aids over blisters. Orders given to staff. Residents mother updated. -January 20, 2025, at 3:27 p.m., written by CNS-D, indicated staff called and sent pictures of R1's right hand. Blisters still intact. Resident's fingertips to second, third and fourth digit blue in color. Resident complained of pain when he tries to close his hand. Blisters not circumferential. Message and pictures sent to provider. Provider ordered ibuprofen 200 mg, take two tabs by mouth three times a day and omeprazole 20 mg one tab by mouth three times a day. -January 21, 2025, at 11:32 a.m., written by CNS-D indicated staff noticed large blister to left third digit. Pictures of left digit and right digits sent to provider. Blister to left digit drained and measures 4 centimeters (cm) and not entirely circumferential. Fingertip slightly blue. Right thumb has a blister at base of the nail measure 1 cm x 1.5 cm. No discoloration noted. Right second digit has blister at the base of finger measuring 2 cm x 1.5 cm and blister to the base of the nail bed measure 0.8 cm x 1.5 cm. Fingertip is blue color. Blister not circumferential. Right third digit does not have any blisters noted. Fingertip is blue in color. Right fourth digit has blister at base of finger measuring 1.5 cm x 2 cm and blister at base of nail bed measuring 1.8 cm x 0.6 cm. Not circumferential. Fingertip blue. Right fifth digit has no blisters, and no discoloration noted. Blisters to right fingers are intact at this time. Provider updated -January 22, 2025, at 2:15 a.m., written by CNS-D indicated R1's provider rounded and R1 was seen. Dressing changes done to blisters on right 1, 2 and 4th digit. Blisters still intact but discoloration, 2nd, 3rd and 4th tips of fingers dark	01620			

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01620	Continued From page 107 in color and spreading on the 4th finger. R1's left 3rd digit blister drained, skin intact. Xerofoam (non-adherent dressing to maintain moisture) dressing applied. Provider decided resident should be evaluated. Resident's mother updated and resident was sent to [facility] ER via [name] van. Report called to ER, resident's mother was going to meet R1 there. Provider notes dated January 22, 2025, indicated superficial frostbite to right hand, and large blister to right hand.. Orders: cleanse area with normal saline or wound cleanser, cover wound bed with Xerofoam, apply 4 x 4 gauze and wrap in Kerlix, change dressing every 3 days and as needed if saturated. R1's Individual Abuse Prevention Plan (IAPP) dated September 23, 2024, did not indicate resident was a smoker, however did indicate R1 was at risk of self abuse due to impaired judgement. According to the Local Conditions website, the temperatures from January 2025 were as follows: - January 18, high temps negative (-) 7 degrees Fahrenheit (F), low temps -13 degrees F; and - January 19, high temps, - 6 degrees F, low temps -13 degrees F. R1's record did not indicate how long R1 was outside, what type of clothing he had on, or number of times per day he went outside to smoke. R1's records indicate 90-day assessments was completed on June 7, 2024, and September 23, 2024 (108 days in between assessments). R1's record did not include any further assessments. R1's 90-day assessment dated September 23,	01620			

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01620	Continued From page 108 2024, indicated ULP to assist resident to wheel outside to smoke each shift as resident desires. Staff to keep lighter securely stored at all times. Resident deemed safe to smoke independently by RN. R1's record lacked a change of condition assessment after R1's fingers became swollen, red and blistered on January 19, 2025. R2 R2's diagnoses included hypertension (high blood pressure). R2's unauthenticated Service Plan dated September 18, 2024, indicated R5 received medication administration, behavior management, and assistance with bathing, grooming, dressing, laundry, and housekeeping. On February 6, 2025, at 3:27 p.m., surveyor received a zip file on R2, however, the file did not contain 90-day assessments as requested. On February 11, 2025, at 11:13 a.m., the surveyor requested via email from (owner)O-B, R2's 90-day or change in condition assessments, however as of February 18, 2025, no assessments were received. R2's record lacked reassessments at least every 90 days. R4 R4's diagnosis included unspecified dementia with behavior disturbance. R4's Service Plan dated January 22, 2025, indicated R4 received medication administration, TEDS (compression stockings), monitoring vital	01620			

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01620	Continued From page 109 signs, and assistance with bathing, grooming, dressing, and light housekeeping. On February 5, 2025, at 9:54 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R4. R4's record lacked all assessments as requested by the surveyor. R5 R5's diagnoses included spastic paresis (increased muscle tension in lower limbs with hyperactive tendon reflexes). R5's unauthenticated Service Plan dated February 5, 2025 (two days after survey initiation), indicated R5 received medication administration, catheter care, positioning/re-positioning, and assistance with bathing, grooming, dressing, laundry, and housekeeping. R5's record included an Assessment dated June 20, 2023 (593 days prior to survey initiation), indicated the reason for the assessment was 90-day lateentry [sic]. R5's record lacked reassessments at least every 90 days. On February 6, 2025, at 3:41 p.m., CNS-D stated CNS-D had not completed resident assessments at least every 90 days, however, CNS-D was aware of the requirement. CNS-D further stated CNS-D was unable to find any assessment for R5 after June 20, 2023, and "seems odd" other assessments for R5 didn't show up in the resident electronic medical record.	01620			

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01620	Continued From page 110 The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated 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. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01620			
01640 SS=F	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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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:	01640			

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01640	Continued From page 111 Based on interview and record review, the licensee failed to ensure the service plan included a licensee signature or other authentication by the licensee and by the resident to document agreement on the services to be provided for three of six residents (R2, R5, R6). 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 affects a large portion or all of the residents). The findings include: During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnoses included hypertension (high blood pressure). R2's Service Plan dated September 18, 2024, indicated R5 received medication administration, behavior management, and assistance with bathing, grooming, dressing, laundry, and housekeeping. R5 R5's diagnoses included spastic paresis (increased muscle tension in lower limbs with hyperactive tendon reflexes). R5's Service Plan dated February 5, 2025 (two	01640			

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01640	Continued From page 112 days after survey initiation), indicated R5 received medication administration, catheter care, positioning/re-positioning, and assistance with bathing, grooming, dressing, laundry, and housekeeping. R6 R6's diagnoses included vascular dementia. R6's Service Plan dated February 5, 2025 (two days after survey initiation), indicated R6 received medication administration, behavior management, and assistance with bathing, grooming, dressing, laundry, and housekeeping. R2, R5 and R6's service plan did not include a licensee signature or other authentication by the licensee and by the resident to document agreement on the services to be provided. On February 6, 2025, at 3:43 p.m., clinical nurse supervisor (CNS)-D stated CNS-D typically printed a resident service plan and placed on assisted living director in residency (ALDIR)-A's desk to obtain signatures. CNS-D further stated CNS-D was aware service plans needed to be signed by the licensee and the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each	01650			

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01650	Continued From page 113 service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans included the required content for three of three residents (R1, R2, R4). 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	01650			

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01650	Continued From page 114 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee was familiar with current minimum assisted living requirements. R1 R1's diagnoses included traumatic brain injury and left sided weakness. R1's Service Plan dated June 7, 2024, indicated R1 received medication administration, assistance with bathing, dressing, grooming, monthly vitals, incontinence cares, brace/splint application and removal, high behavior management, smoking assistance, housekeeping, and laundry. On February 4, 2025, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-F and ULP-G perform morning cares for R1. R2 R2's diagnoses included hypertension (HTN- high blood pressure). R2's Service Plan dated September 18, 2024, indicated R5 received medication administration, behavior management, and assistance with bathing, grooming, dressing, laundry, and housekeeping. R4 R4's diagnosis included unspecified dementia with behavior disturbance.	01650			

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01650	Continued From page 115 R4's Service Plan dated January 22, 2025, indicated R4 received medication administration, TEDS (compression stockings), monitoring vital signs, and assistance with bathing, grooming, dressing, and light housekeeping. On February 5, 2025, at 9:54 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R4. R1, R2, and R4's service plans indicated the initial resident assessment will be completed within 5 (five) days after initiation of home care services. R1, R2, and R4's service plans lacked the schedule and methods of monitoring assessments of the residents per assisted living regulations. On February 6, 2025, at 3:43 p.m., clinical nurse supervisor (CNS)-D stated resident service plans are developed based off the resident assessment and any additional needs the resident wanted. CNS-D further stated the licensee's electronic resident medical record system automatically included service plan content, and CNS-D was not aware of the required content of a service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated	01750			

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01750	Continued From page 116 to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: This correction order was modified on February 14, 2025, to add additional information regarding an interview with RN-J on February 6, 2025. Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the nursing task of medication administration, the registered nurse (RN) instructed the unlicensed personnel (ULP) in proper methods to administer the medications and the ULP demonstrated competency back to the RN for administering medications for two of two ULPs (ULP-F, ULP-G). This had the potential to affect all 15 residents receiving assisted living services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01750			

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01750	Continued From page 117 The findings include: This resulted in an immediate correction order on February 6, 2025. During the entrance conference on February 3, 2025, owner (O)-B stated upon hire ULPs completed online training, ULPs shadowed other ULPs, ULPs completed skills competency (O-B did not indicate with whom), and ULPs proceeded to work independently. ULP-F ULP-F was hired on August 30, 2024, to provide direct care services to residents at the facility. ULP-F's employee record lacked sufficient evidence ULP-F was trained for medication administration by the RN and demonstrated medication administration competency back to the RN. On February 5, 2025, at 9:58 a.m., ULP-F stated ULP-F had been employed at the facility for four months. ULP-F further stated ULP-F was trained in, including medication administration, and orientated to residents by other ULPs at the facility. ULP-F stated RN-J had watched ULP-F administer a "few" medications after ULP-F had passed resident medications with other ULPs without RN supervision or deemed competent by the RN. On February 5, 2025, at 12:42 p.m., the surveyor observed ULP-F provide scheduled insulin medication administration to R7. ULP-F removed R7's Novolog 100 units insulin flex pen from the medication closet, however, R7's Novolog insulin flex pen was not labeled with a prescription label, the time sensitive open date or expiration date, or	01750			

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01750	Continued From page 118 any identifying information for R7. ULP-F put on gloves, without cleaning the insulin pen hub (place on insulin pen to attach the needle) placed the needle on the insulin pen, dialed the insulin pen to two units and discarded, and ULP-F proceeded to dial the insulin pen to four units. ULP-F entered the living room space area, off the kitchen, where R7 was in a recliner along with four other residents seated in the same room. ULP-F stated to R7 it was time to administer R7's insulin, lifted R7's shirt which exposed R7's abdomen, cleansed R7's upper left quadrant, and administered R7's scheduled insulin. ULP-F removed the needle from R7's insulin pen, placed the cap back onto R7's insulin pen, ULP-F removed gloves, and returned to the medication closet to document the administration of R7's insulin on the electronic medication administration record (EMAR). The surveyor did not observe ULP-F clean R7's insulin pen prior to application of the needle or compare R7's Novolog insulin pen to R7's EMAR at any point prior to administration of R7's insulin. Immediately following the observation, ULP-F stated ULP-F was not trained to check the EMAR prior to administering insulin, ULP-F was not aware a prescription label should have been on the insulin pen to identify if it was R7's insulin pen, and ULP-F was not aware R7's insulin pen should have been labeled with an open date or expiration date. ULP-F's employee record contained a New Hire Orientation Checklist dated August 30, 2024. On page four: section RN, indicated medication administration completed 9/2 (September 2, 2024) by manager (M)-C (not an RN) and the observation space was left blank. Page five of New Hire Orientation Checklist included signatures of ULP-F and M-C. Written directly	01750			

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01750	Continued From page 119 below M-C's signature was "M-C housing manager reviewed all RN skills packet and RN signed packet on date that she (RN-C) reviewed" signed by O-B, however, was not dated. O-B was also not a RN. Below the written statement was clinical nurse supervisor (CNS)-D's signature with no date. ULP-F's employee record contained a Skill Assessments form dated September 18, 2024, indicating ULP-F had passed medication administration, which included insulin pen administration. On page 31 the RN signature and date were left blank, however, a note was written "signed on back paper also med (medications) trained on two spots whole thing [sic]." RN-J signed page 32 on September 18, 2024. On February 5, 2025, at 12:54 p.m., M-C stated M-C went over the training listed on ULP-F's orientation pages and stated that M-C was identified on ULP-F's orientation form as the trainer. On February 6, 2025, at 7:53 a.m., ULP-F stated RN-J had only observed ULP-F complete medication administration for oral medications and not topical, insulin, patches, or inhaler medications. ULP-F further stated when ULP-F started medication administration independently without another ULP to assist, ULP-F had to contact CNS-D daily via phone to walk ULP-F through medication administration to ensure the medication administration process was being completed correctly. ULP-G ULP-G was hired on November 27, 2023, to provide direct care services to residents at the facility.	01750			

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01750	Continued From page 120 ULP-G's employee record lacked sufficient evidence ULP-G was trained for medication administration by the RN and demonstrated medication administration competency back to the RN. On February 5, 2025, at 9:19 a.m., ULP-G stated ULP-F was the medication passer for the licensee for the shift, however, ULP-G had passed medications on other days and shifts. On February 5, 2025, at 12:41 p.m., ULP-G stated ULP-G was trained and competency tested by M-C and other ULPs at the facility. ULP-G further stated ULP-G had not been trained or competency tested by an RN. ULP-G stated ULP-G was told to sign ULP-G's name on all the documentation upon hire even though training and competency testing had not been completed. ULP-G's employee record contained a New Hire Orientation Checklist dated December 5, 2023. Pages one through five had arrows with lines documented in pink ink. On page four section RN, indicated medication administration completed 12/6 (December 6, 2023) by an employee with initials identified as a ULP. Next to the ULP's initials was written RN. Page five of New Hire Orientation Checklist included signatures of ULP-G in black ink and O-B's signature in pink ink. Written below O-B's signature was CNS-D's signature with the date of December 6, 2023, in black ink. ULP-G's employee record contained a Knowledge Assessment Medication Administration and Medication Administration-Overview form dated December 1, 2023, signed by O-B.	01750			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 121 ULP-G's employee record contained a Skill Assessments form dated December 6, 2023, indicating ULP-G had passed medication administration. Pages one through 30 of the Skill Assessments were stapled together, with an additional loose page 31 that followed which was not stapled to the packet, and did not have staple holes to indicate page 31 had been previously attached to the Skill Assessments. Page 31 did contain CNS-D's signature. On February 5, 2025, at 12:46 p.m., CNS-D stated the ULP's are trained by online training, then ULP's train the new ULP's while working the floor and do a big skills packet. CNS-D stated then she would test them on the skills. Additionally, CNS-D stated M-C did the on-boarding, and went through new hire orientation. On February 5, 2025, at 1:34 p.m., CNS-D stated CNS-D did not provide the medication training to ULPs, however, CNS-D watched ULPs complete all medication administration routes "whether they (ULPs) know or not", and then CNS-D signed the competency forms. CNS-D further stated CNS-D was not sure why ULP-G's original Skill Assessment forms did not include CNS-D's original signature page. On February 5, 2025, at 7:01 p.m., the surveyor left a voicemail for RN-J, however, the surveyor did not receive a call back. On February 6, 2025, at 9:52 a.m., RN-J returned the surveyor's phone call from February 5, 2025. RN-J stated RN-J had deemed ULP-F competent to complete medication administration to residents after ULP-F had trained on the floor	01750			

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01750	Continued From page 122 with a "lead" ULP. RN-J stated RN-J observed one oral medication pass for a resident with ULP-F, however, did not observe ULP-F administer any resident insulin, topical medications, inhalers, or apply medication patches since that specific resident did not have any other routes of medications to be administered at that time of the medication administration. The licensee's 8.02 Competency Training Evaluations policy dated July 1, 2021, indicated when a RN delegates tasks, prior to the delegation of services they (RN) must make certain the ULP is trained in the proper methods to person the tasks or procedures for each client (resident) and are able to demonstrate the ability to competently follow the procedures and perform the tasks [sic]. This policy included medication administration. The licensee's 7.36 Insulin policy dated August 1, 2021, indicated ULPs must be trained, and competency tested by a RN. In addition, the policy indicated to compare the information of the MAR (medication administration record) with the label on the medication container. If you (ULP) cannot read the label, or if the MAR and label do not all say the same thing, stop and call the nurse for instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup,	01770			

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01770	Continued From page 123 name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R4). 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: During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee provided medication management services to the residents. R4's diagnosis included unspecified dementia with behavior disturbance. R4's Service Plan dated January 22, 2025, indicated R4 received medication administration three times daily. R4's record lacked prescriber orders. R4's Med (medication) Admin (administration) Summary dated January 2025, indicated lorazepam 0.5 milligrams (mg) tablet take one	01770			

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01770	Continued From page 124 tablet by mouth three times daily and lorazepam 2 mg/milliliter (mL) take 0.5 mL by mouth as needed every three hours. On February 5, 2025, at 9:37 a.m., the surveyor observed unlicensed personnel (ULP)-F was unable to locate R4's lorazepam 0.5 mg tablets. ULP-F called clinical nurse supervisor (CNS)-D via telephone to report R4 was out of lorazepam 0.5 mg tablets. CNS-D instructed ULP-F to administer one of R4's syringes that contained lorazepam 0.5 mL liquid and CNS-D would contact the pharmacy for a refill of R4's lorazepam 0.5 mg tablets. ULP-F opened the medication refrigerator, removed one of R4's lorazepam 0.5 mL syringes from a labeled baggie with R4's name, and placed the remaining seven syringes of R4's lorazepam 0.5 mL back into the refrigerator. ULP-F stated CNS-D had set up R4's lorazepam 0.5 mL syringes. R4's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup. On February 6, 2025, at 3:49 p.m., CNS-D stated CNS-D completed medication set ups for residents at the facility, however, CNS-D was not aware required documentation for the medication set ups. CNS-D further stated when CNS-D completed a medication set up CNS-D had only documented the increased number of syringes in the narcotic log. The licensee's 7.08 Medication Management-Administration and Setup policy dated August 1, 2021, indicated a licensed nurse will correctly and	01770			

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01770	Continued From page 125 accurately document any medication setup provided. The policy did not address the content of the medication setup documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must	01790			

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01790	Continued From page 126 address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed	01790			

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01790	Continued From page 127 to ensure two of two ULPs (ULP-F, ULP-G) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee provided medication management services to the residents. O-B further stated upon hire ULPs completed online training, ULPs shadowed other ULPs, ULPs completed skills competency (O-B did not indicate with whom), and ULPs proceeded to work independently. UNPLANNED TIME PROCEDURE FOR ULP The undated Skills Assessment on page 13 indicated the licensee's procedure for Medications Sent out of Facility, however, the procedure failed to address how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned. TRAINING AND COMPETENCY EVALUATIONS ULP-F ULP-F was hired on August 30, 2024, to provide direct care services to residents at the facility.	01790			

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01790	Continued From page 128 On February 5, 2025, at 9:54 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R4. ULP-F's employee record contained a New Hire Orientation Checklist dated August 30, 2024. On page four: section RN, indicated medication administration completed 9/2 (September 2, 2024) by manager (M)-C (not a RN) and the observation space was left blank. Page five of New Hire Orientation Checklist included signatures of ULP-F and M-C. Written directly below M-C's signature was "M-C housing manager reviewed all RN skills packet and RN signed packet on date that she (RN-C) reviewed" signed by O-B, however, was not dated. O-B was also not a RN. Below the written statement was clinical nurse supervisor (CNS)-D's signature with no date. ULP-F's employee record contained a Skill Assessments form dated September 18, 2024, which indicated ULP-F had passed Medications Sent out of Facility on page 13. On page 31 the RN signature and date were left blank, however, a note was written "signed on back paper also med (medications) trained on two spots whole thing [sic]." RN-J signed page 32 on September 18, 2024. ULP-F's employee record lacked sufficient evidence ULP-F was trained and deemed competent to complete resident's unplanned time away. On February 5, 2025, at 9:58 a.m., ULP-F stated ULP-F had been employed at the facility for four months. ULP-F further stated ULP-F was trained in, including medication administration, and	01790			

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01790	Continued From page 129 orientated to residents by other ULPs at the facility. ULP-F stated RN-J had watched ULP-F administer a "few" medications after ULP-F had passed resident medications with other ULPs without RN supervision or deemed competent by the RN. ULP-G ULP-G was hired on November 27, 2023, to provide direct care services to residents at the facility. On February 5, 2025, at 9:19 a.m., ULP-G stated ULP-F was the medication passer for the licensee for the shift, however, ULP-G had passed medications on other days and shifts. ULP-G's employee record contained a New Hire Orientation Checklist dated December 5, 2023. Pages one through five had arrows with lines documented in pink ink. On page four section RN, indicated medication administration completed 12/6 (December 6, 2023) by an employee with initials identified as a ULP. Next to the ULP's initials was written RN. Page five of New Hire Orientation Checklist included signatures of ULP-G in black ink and O-B's signature in pink ink. Written below O-B's signature was CNS-D's signature with the date of December 6, 2023, in black ink. ULP-G's employee record contained a Knowledge Assessment Medication Administration and Medication Administration-Overview form dated December 1, 2023, signed by O-B. ULP-G's employee record contained a Skill Assessments form dated December 6, 2023, which indicated ULP-G had passed Medications	01790			

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01790	Continued From page 130 Sent out of Facility. Pages one through 30 of the Skill Assessments were stapled together, with an additional loose page 31 that followed which was not stapled to the packet, and did not have staple holes to indicate page 31 had been previously attached to the Skill Assessments. Page 31 did contain CNS-D's signature. ULP-G's employee record lacked sufficient evidence ULP-G was trained and deemed competent to complete resident's unplanned time away. On February 5, 2025, at 12:41 p.m., ULP-G stated ULP-G was trained and competency tested by M-C and other ULPs at the facility. ULP-G further stated ULP-G had not been trained or competency tested by an RN. ULP-G stated ULP-G was told to sign ULP-G's name on all the documentation upon hire even though training and competency testing had not been completed. On February 5, 2025, at 12:46 p.m., CNS-D stated the ULPs are trained by online training, then ULPs train the new ULPs while working the floor and do a big skills packet. CNS-D stated then CNS-D would test them on the skills. Additionally, CNS-D stated M-C did the on-boarding, and went through new hire orientation. On February 5, 2025, at 1:34 p.m., CNS-D stated CNS-D did not provide the medication training to ULPs, however, CNS-D watched ULPs complete all medication administration routes "whether they (ULPs) know or not", and then CNS-D signed the competency forms. CNS-D further stated CNS-D was not sure why ULP-G's original Skill Assessment forms did not include CNS-D's original signature page.	01790			

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01790	Continued From page 131 On February 6, 2025, at 9:52 a.m., RN-J returned the surveyor's phone call from February 5, 2025. RN-J stated RN-J had deemed ULP-F competent to complete medication administration to residents after ULP-F had trained on the floor with a "lead" ULP. RN-J stated RN-J observed one oral medication pass for a resident with ULP-F, however, RN-J did not observe ULP-F complete a blood glucose test or any other competencies. RN-J further stated RN-J was just helping out the licensee and had only been employed at the licensee for a short time. On February 6, 2025, at 3:34 p.m., M-C stated the licensee used the same training and competency process upon hire for all ULPs. On February 6, 2025, at 3:40 p.m., CNS-D stated we (the licensee) gave you (the surveyors) all the information the licensee had available for employee records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01820			

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01820	Continued From page 132 review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for two of three residents (R1, R4) who received medication management 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 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: During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee provided medication management services to the residents. R1 R1's diagnoses included traumatic brain injury and left sided weakness. R1's service plan dated June 7, 2024, indicated R1 received medication administration, assistance with bathing, dressing, grooming, monthly vital signs, incontinence cares, brace/splint application and removal, high behavior management, smoking assistance, housekeeping, and laundry. On February 4, 2025, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-F and ULP-G perform morning cares for R1. On February 4, 2025, at 9:24 a.m., the surveyor	01820			

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01820	Continued From page 133 requested R1's record via email (electronic mail) to O-B including signed prescriber orders. R1's Med (medication) Admin (administration) Summary dated January 2025, included the following medications: - Depakote (treats seizures) 250 milligrams (mg) three times daily; - docusate sodium (treats constipation) 200 mg twice daily; - ibuprofen (treats pain) 400 mg three times daily; - metoprolol (treats high blood pressure) 25 mg daily; - omeprazole (treats acid reflux) 20 mg twice daily; - polyethylene glycol (treats constipation) 17 grams (g) every other day; - vitamin D3 (supplement) 50 micrograms (mcg) daily; - gabapentin (treats nerve pain) 400 mg daily; - sertraline (treats depression) 50 mg daily; - trazadone (treats insomnia) 50 mg daily; - Zoloft (treats depression) 75 mg daily; - mirabegron (treats overactive bladder) 50 mg daily; - hydro-acetaminophen (for pain) 5-325 mg every six hours as needed (PRN); and - several PRN (as needed) over the counter pain (OTC) medications for dry eyes, constipation, loose stools, ointments, cough syrup, and heartburn pain. R4 R4's diagnosis included unspecified dementia with behavior disturbance. R4's Service Plan dated January 22, 2025, indicated R4 received medication administration, TEDS (compression stockings), monitoring vital signs, and assistance with bathing, grooming,	01820			

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01820	Continued From page 134 dressing, and light housekeeping. On February 5, 2025, at 9:54 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R4. On February 5, 2025, at 10:39 a.m., the surveyor requested R4's record via email to O-B including signed prescriber orders. On February 6, 2025, at 1:49 p.m., the surveyor requested R4's record via email to O-B including signed prescriber orders a second time. R4's Med Admin Summary dated January 2025, included the following medications: - budesonide (treats difficult breathing) 1 mg/2 milliliters (mL) inhale 2 mL twice daily; - dok (docusate sodium) (treats constipation) 100 mg daily; - furosemide (treats fluid retention) 40 mg daily; - i prat-albuterol (treats difficult breathing) 0.5-3 mg/3 mL inhale 3 mL daily; - lorazepam (treats anxiety) 0.5 mg three times daily; - prednisone (treats inflammation) 2.5 mg daily; - quetiapine (antipsychotic) 50 mg three times daily; - Trolamine (treats arthritis) cream 10% apply topically twice daily; and - trazodone (treats insomnia) 100 mg daily. R1 and R4's record lacked signed prescriber orders for medications to be administered by the licensee. On February 6, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-D stated the prescriber orders were individual orders. CNS-D stated O-B would email the orders.	01820			

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01820	Continued From page 135 On February 6, 2025, at 2:40 p.m., O-B stated O-B was waiting for prescriber's orders to come in and then would email the prescriber orders to the surveyor. On February 6, 2025, at 3:01 p.m., O-B stated O-B had to download resident orders one at a time. O-B further stated the licensee's IT (technical support) for the resident's electronic resident medical records was gone until next Tuesday (February 11, 2025) to assist O-B with providing resident record information which was requested by surveyors. On February 6, 2025, at 3:47 p.m., CNS-D stated the licensee did not have individual orders available for the above residents in the resident's record, and CNS-D would need to go into the provider portal (electronic health record for the physician) to print out each individual medication order. The licensee's 7.12 Medications- Prescribed, Not Prescribed and OTC policy dated August 1, 2021, indicated (licensee name) will determine whether the facility shall require a prescription for all medications the provider manages. In addition, the nursing staff will follow the policy for medications orders as determined necessary. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=I	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880			

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01880	Continued From page 136 prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were securely locked and permitted access to only authorized personnel for medications located inside of a shared office. This had the potential to affect all four residents, staff, and visitors. This resulted in an immediate correction order identified on February 4, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's current client roster dated February 3, 2025, indicated 15 residents received services from the assisted living licensee. Primary diagnosis for five of the residents was a type of dementia (vascular dementia, dementia, and Alzheimer's dementia), and two residents had traumatic brain injuries. On February 3, 2025, at 9:30 a.m., the surveyor arrived at the facility and was led to an office with three desks. Unlicensed personnel (ULP)-E	01880			

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01880	Continued From page 137 unlocked the office door and stated this was the director and nurse office. The entrance door to the office shared a commons area with resident room #10/11 (shared room, one resident currently) and #12 (single room, one resident currently). The commons area opened to the living area with a television, where the surveyor observed residents sitting during the day. A long hallway off of the living area had six resident rooms, all occupied. The surveyor observed one desk with blister packs of medications laying on top of the desk, a large clear tote with no lid and two unsecured clear file cabinets with various blister packs of medications, bottles of medications, and various over the counter supplements. On February 3, 2025, at 10:08 a.m., manager (M)-C arrived at the facility. During the entrance conference on February 3, 2025, at 10:14 a.m., owner (O)-B stated via phone the licensee provided medication management services to residents at the facility. On February 3, 2025, at 11:00 a.m., the surveyor asked M-C about the desk with the medications. M-C stated it was the nurse's desk and she takes care of the medications. During the tour at 11:05 a.m., the surveyor observed the locked medication room with ULP-E. ULP-E stated the refrigerator inside the medication room was not keeping temperature, so medications were moved to the refrigerator in the office. On February 3, 2025, at 11:40 a.m., the surveyor and ULP-E observed the unsecured medication refrigerator (with no temperature gauge) in the	01880			

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01880	Continued From page 138 office that contained the following: - eight boxes of Novolog flex pens (short acting insulin); - three boxes of glargine insulin pens (long-acting insulin); - two vials of shingles vaccination; - one ADACEL TDAP vaccination; - one partial bottle of Lorazepam 2 milligram (mg)/milliliters (ml) solution (for anxiety) (16 ml in bottle); and - two bottles of Megestrol 40 mg/ml solution (hormone therapy). On February 3, 2025, at 11:45 p.m., ULP-E stated if they (ALDIR-A, CNS-D or M) were on-site the door was left unlocked during the day. On February 3, 2025, at 12:10 p.m., the surveyor observed the following medications in the office either on the desk, in the large clear container, and two clear plastic containers with drawers. -forty-eight different prescriptions in bottles or blister packs to include, but not limited to, quetiapine (for mood swings), gabapentin (for nerve pain), olanzapine (for mania episodes), divalproex (for seizures), liquid morphine 20 mg/ml (for pain) (15 ml left in bottle), mirtazapine, bupropion and sertraline (for depression), benazepril, and lisinopril (for high blood pressure) and atorvastatin (for high cholesterol). On February 3, 2025, at 3:52 p.m., M-C verified lorazepam solution from the refrigerator had 16 ml in the bottle and morphine bottle from the nurse desk area contained 15 ml in the bottle. M-C stated when controlled substances come in the hospice nurse or clinical nurse supervisor deals with the medications. The lorazepam was placed back into the refrigerator, and M-C placed the morphine back to the nurses desk and stated	01880			

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01880	Continued From page 139 the nurse would manage it her next time at the facility. On February 3, 2025, from 9:30 a.m. to 4:00 p.m., the surveyor observed the office to be unlocked. M-C left the office to help serve lunch, toured with the surveyors, left the office for phone calls, and shoveled snow. At times, the surveyor was left alone in the office to review documents, survey engineer was also in the office and at times there was no one present in the office. M-C did not lock the office when she left the office during the day. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for three of three residents (R7, R11, R12). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890			

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01890	Continued From page 140 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: During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee provided medication management services to the residents. On February 3, 2025, at 11:10 a.m., the surveyor observed the locked medication room with unlicensed personnel (ULP)-E. ULP-E confirmed the following medications did not bear an original prescription label, including open or expiration dates for time sensitive medications: ORIGINAL PHARMACY LABELS/TIME SENSITIVE MEDICATIONS -R7's opened glargine 100 units/milliliter (ml) insulin pen, (used to treat high blood sugar) lacked original prescription label and open and expiration dates; and -R7's Novolog opened 100 units/ml Flexpen, (used to treat high blood sugar) lacked original prescription label and open and expiration dates. TIME SENSITIVE MEDICATIONS -R11's opened Symbicort 160/4.5 mcg inhaler (used to reduce lung inflammation) lacked opened and expiration dates; -R11's opened Stiolto Respimat (relieves muscles around the airways) lacked opened and expiration dates; -R12's opened Latanoprost 0.005% eye drop	01890			

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01890	Continued From page 141 (used to lower eye pressure) lacked open and expiration dates; and -R12's opened Trelegy 100 microgram (mcg)/62.5 mcg/25mcg inhaler (used to treat chronic obstructive pulmonary disease) lacked opened and expiration dates. On February 3, 2025, at 11:25 a.m., ULP-E stated the insulins should have pharmacy labels on with open and expire dates and did not know why the insulins were not labeled. ULP-E further stated ULP-E was not aware eyedrops and inhalers needed opened and expiration date. On February 5, 2025, at 12:42 p.m., the surveyor observed ULP-F provide scheduled insulin administration for R7. R7's Novolog 100 units insulin flex pen did not bear the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. Immediately following the above observation, ULP-F stated ULP-F was not trained to ensure medications had the original prescription label or the medication should be stored in the original box bearing the prescription label. ULP-F further stated ULP-F was not aware insulin pens should be labeled with an open date and expiration date of the time sensitive medication. On February 6, 2025, at 2:06 p.m., ULP-E stated the licensee must have run out of the stickers to place on time sensitive medications which prompted ULPs to write the open date and expiration date of each medication. On February 6, 2025, at 3:48 p.m., clinical nurse supervisor (CNS)-D stated CNS-D was not sure what happened to the opened date labels the	01890			

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01890	Continued From page 142 licensee used to use for time sensitive medications, and CNS-D was not aware each medication should bear the original prescription label or be stored in the original container with the original prescription label. The manufacturer instructions for glargine insulin pen dated June 2022, indicated to discard opened glargine insulin pens after 28 days even if the insulin pen still contained insulin. The manufacturer's instructions for Novolog flex pen dated October 2021, indicated to discard opened Novolog flexpens after 28 days even if the flexpen still contained insulin. The manufacturer instructions for Symbicort inhaler dated December 2022, indicated to discard three months after opening the foil pouch, or until the dose counter reads zero, whichever comes first. The manufacturer instructions for Stiolto Respimat inhaler dated December 2022, indicated to discard three months after its first use even if there is medicine in it. The manufacturer instructions for Latanoprost solution dated March 2022, indicated to discard any remaining solution after four weeks from the date of opening. The manufacturer instructions for Trelegy inhaler dated December 2022, indicated to discard inhaler six weeks after the tray is open or when the tray reads zero, whichever comes first. The licensee's 7.12 Medications-Prescribed, Not Prescribed and Over the Counter (OTC) policy dated August 1, 2021, indicated the facility must	01890			

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01890	Continued From page 143 verify that the medications are up to date and stored as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01950 SS=I	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: This correction order was modified on February 14, 2025, to add additional information regarding an interview with RN-J on February 6, 2025. Based on observation, interview, and record review, the licensee failed to ensure prior to	01950			

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01950	Continued From page 144 delegating nursing tasks of treatment administration, the unlicensed personnel (ULP) were trained in the proper methods to perform blood glucose testing and the ULP demonstrated competency back to the registered nurse (RN) for two of two employees (ULP-F, ULP-G). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on February 6, 2025. During the entrance conference on February 3, 2025, owner (O)-B stated upon hire ULPs completed online training, ULPs shadowed other ULPs, ULPs completed skills competency (O-B did not indicate whom) , and ULPs proceeded to work independently. ULP-F ULP-F was hired on August 30, 2024, to provide direct care services to residents at the facility. ULP-F's employee record lacked sufficient evidence ULP-F was trained for blood glucose testing by the RN and demonstrated blood glucose testing competency back to the RN. On February 5, 2025, at 9:58 a.m., ULP-F stated ULP-F had been employed at the facility for four	01950			

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01950	Continued From page 145 months. ULP-F further stated ULP-F was trained in, including blood glucose testing, and orientated to residents by other ULPs at the facility. ULP-F stated RN-J had watched ULP-F administer a "few" medications, however, ULP-F stated ULP-F did not demonstrate blood glucose testing to RN-J. On February 5, 2025, at 11:32 a.m., the surveyor observed ULP-F complete a blood glucose test for R7 at the dining room table with two other residents seated at the table. ULP-F cleansed R7's pinky finger on R7's R hand, poked R7's finger, squeezed blood from R7's finger onto the glucometer, and stated to R7 the ready was 106 milligrams (mg)/ deciliter (dL). Immediately following the observation, ULP-F stated R7 would receive insulin administration after R7 ate lunch and returned to the medication storage closet to document on R7's electronic treatment administration record (ETAR) R7's blood glucose test. ULP-F's employee record contained a New Hire Orientation Checklist dated August 30, 2024. On page four: section RN, indicated blood glucose glucometer (machine used to test blood sugar levels in a resident's blood) was left blank for training and observation dates. On page five of New Hire Orientation Checklist included signatures of ULP-F and manager (M)-C. Written directly below M-C's signature was "M-C housing manager reviewed all RN skills packet and RN signed packet on date that she (RN-C) reviewed" signed by O-B, however, was not dated. O-B was not a RN. Below the written statement was clinical nurse supervisor (CNS)-D's signature with no date of authenticity. ULP-F's employee record contained a Skill	01950			

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01950	Continued From page 146 Assessments form dated September 18, 2024, indicating ULP-F had passed Blood Glucose Glucometer Test. On page 31 the RN signature and date were left blank, however, a note was written "signed on back paper also med (medications) trained on two spots whole thing [sic]." RN-J signed page 32 on September 18, 2024. On February 5, 2025, at 12:54 p.m., M-C stated M-C went over the training listed on ULP-F's orientation pages and stated that M-C was identified on ULP-F's orientation form as the trainer. M-C was not a RN. ULP-G ULP-G was hired on November 27, 2023, to provide direct care services to residents at the facility. ULP-G's employee record lacked sufficient evidence ULP-G was trained for blood glucose testing by the RN and demonstrated blood glucose competency back to the RN. On February 5, 2025, at 12:41 p.m., ULP-G stated ULP-G was trained and competency tested by M-C and other ULPs at the facility. ULP-G further stated ULP-G had not been trained or competency tested by an RN. ULP-G stated ULP-G was told to sign ULP-G's name on all the documentation upon hire even though training and competency testing had not been completed. ULP-G's employee record contained a New Hire Orientation Checklist dated December 5, 2023. Pages one through five had arrows with lines documented in pink ink. Page four: section RN, indicated blood glucose testing was completed 12/6 (December 6, 2023) by an employee with	01950			

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01950	Continued From page 147 initials identified as a ULP. Next to the ULP's initials was written RN. On page five of New Hire Orientation Checklist included signatures of ULP-G in black ink and O-B's signature in pink ink. Written below O-B's signature was CNS-D's signature with the date of December 6, 2023, in black ink. ULP-G's employee record contained a Knowledge Assessment Blood Glucose Testing dated December 1, 2023, signed by O-B. ULP-G's employee record contained a Skill Assessments form dated December 6, 2023, indicating ULP-G had passed blood glucose glucometer test. Pages one through 30 of the Skill Assessments were stapled together, with an additional loose page 31 that followed which was not stapled to the packet, and did not have staple holes to indicate page 31 had been previously attached to the Skill Assessments. Page 31 did contain CNS-D's signature. On February 5, 2025, at 12:46 p.m., CNS-D stated the ULPs were trained by online training, then ULPs train the new ULPs while working the floor and do a big skills packet. CNS-D stated then she would test them on the skills. Additionally, CNS-D stated M-C did the on-boarding, and went through new hire orientation. On February 5, 2025, at 1:34 p.m., CNS-D stated CNS-D did not provide training to ULPs, however, CNS-D watched ULPs complete delegated tasks after ULPs completed training with ULPs on the floor "whether they (ULPs) know or not", and then CNS-D signed the competency forms. CNS-D further stated CNS-D was not sure why ULP-G's original Skill Assessment forms did not include	01950			

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01950	Continued From page 148 CNS-D's original signature page. On February 5, 2025, at 7:01 p.m., the surveyor left a voicemail for RN-J, however, the surveyor did not receive a call back. On February 6, 2025, at 9:52 a.m., RN-J returned the surveyor's phone call from February 5, 2025. RN-J stated RN-J did not observe ULP-F complete a blood glucose test to be deemed competent to provide the delegated treatment, however, RN-J had talked about a blood glucometer with ULP-F. The licensee's 8.02 Competency Training Evaluations policy dated July 1, 2021, indicated when a RN delegates tasks, prior to the delegation of services they (RN) must make certain the ULP is trained in the proper methods to person the tasks or procedures for each client (resident) and are able to demonstrate the ability to competently follow the procedures and perform the tasks [sic]. This policy included the use of glucometers. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01950			
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be	01970			

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01970	Continued From page 149 renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded prescriptions were obtained for two of three residents (R1, R4) who received treatment management 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 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: During the entrance conference on February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee provided treatment and therapy to residents. R1 R1's diagnoses included traumatic brain injury and left sided weakness. R1's service plan dated June 7, 2024, indicated R1 received supervision for brace/splint application, however, the service plan did not include blood glucose monitoring as needed. R1's 90-day assessment dated September 23, 2024, indicated unlicensed personnel (ULPs) to assist resident with left leg and left arm braces as	01970			

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01970	Continued From page 150 needed per R1's request. R1's treatment recap summary dated January 2025, indicated R1 received assistance with brace/splint application/removal twice daily. R1's electronic medication administration record dated January 2025, indicated blood glucose monitoring as needed for symptomatic blood glucose concerns. On February 4, 2025, at 7:35 a.m., the surveyor observed ULP-F and ULP-G perform morning cares for R1. On February 4, 2025, at 9:24 a.m., surveyor requested R1's record via email (electronic mail) to O-B including signed prescriber orders. R1's record lacked prescriber orders for blood glucose monitoring as needed and brace/splint application and removal daily. R4 R4's diagnosis included unspecified dementia with behavior disturbance. R4's Service Plan dated January 22, 2025, indicated TED stocking (compression stockings to reduce swelling in the legs) placement daily and TED stocking removal daily. On February 5, 2025, at 9:54 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R4. On February 5, 2025, at 10:39 a.m., the surveyor requested R4's record via email to O-B including signed prescriber orders.	01970			

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01970	Continued From page 151 On February 6, 2025, at 1:49 p.m., the surveyor requested R4's record via email to O-B including signed prescriber orders for a second time. R4's record lacked signed prescriber order for TEDS. On February 6, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-D stated the prescriber orders were individual orders. CNS-D stated O- B would email the orders. On February 6, 2025, at 2:40 p.m., O-B stated O-B was waiting for prescriber's orders to come in and then would email the prescriber orders to the surveyor. On February 6, 2025, at 3:47 p.m., CNS-D stated CNS-D was not aware a prescriber order was needed for each resident's delegated treatments. CNS-D further stated the licensee was not aware annual prescriber orders were required. The licensee's 7.05 Treatment and Therapy Management Plan policy dated August 1, 2021, indicated for each resident at (licensee name) receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310			

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02310	Continued From page 152 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R8) with hospital bedrails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on February 6, 2025. R8's diagnoses included dementia. R8's unsigned service plan dated February 5, 2025, (completed after survey entrance), indicated R8 received medication management, assistance with incontinent cares, toileting, repositioning compression stockings, bathing, dressing, grooming, ambulation, smoking, monthly vitals, laundry, and housekeeping.	02310			

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02310	Continued From page 153 R8's 90-day assessment dated November 14, 2024, indicated R8 had a standard bed frame, original mattress to the bed and no assistive devices needed for bed. R8's assessment indicated R8 needed 24-hour supervision and staff will observe resident from potentially abusive/harmful situations. On September 24, 2024, at 10:30 p.m., an incident report indicated R8 was found by an unlicensed personnel (ULP) half on the floor and half on the bed when checking on R8, as R8 was yelling. The ULP indicated in the report R8 was hanging on to the side rail of the bed and R8's butt and legs were on the floor. R8 stated R8 was trying to get up, as R8 was tired of laying down. The ULP also indicated on the report R8's bed alarm was unplugged. ULP indicated R8 had a bruise (no location), manager (M)-C was notified via phone at 10:34 p.m., to assist with getting R8 off the floor. Registered Nurse (RN)-J was notified at 11:04 p.m. RN-J documented on September 26, 2024, R8 was assisted off the floor and assessed for injuries and was educated on importance to call for help. On February 5, 2025, at 2:43 p.m., the surveyor observed R8's hospital bed had one left single upper bedrail in the upright position. On February 5, 2025, from 2:15 p.m. to 2:52 p.m., clinical nurse supervisor (CNS)-D stated seven residents had hospital bed rails, there were two residents (including R8) with no bed rail assessments, and five other residents with no measurements for entrapment or manufacturer instructions. CNS-D could not give a reason why the bed rails assessments were not completed. On February 5, 2025 at 2:07 p.m., surveyor	02310			

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02310	Continued From page 154 asked CNS-D to measure the bed rail, CNS-D stated CNS-D was unsure how to measure bed rails. The surveyor gave CNS-D an example of a bed rail and potential zones of entrapment. CNS-D stated R8's bed rail was a left sided upper metal half side rail with vertical bars and potential zones of entrapment, measurements; Zone 1: 4 1/4/inches, Zone 2: 0 inches, Zone 3: 1 1/2 inches, Zone 4: 0 inches. CNS-D stated the bed rail was not stable, there is too much "give", and CNS-D would be calling the company that the bed came from to have them come look at it. R8's record lacked a comprehensive assessment on the use of a bedrail to include: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - Measurement zones of the bedrail; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee's 6.01 Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going	02310			

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02310	Continued From page 155 assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated 12/13/2024, indicated to ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. In addition, documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct	02310			

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02310	Continued From page 156 installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Furthermore, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendation. Minnesota Rules - Assisted Living Facilities 4659.0150 Uniform Assessment Tool, subdivision 2 indicated each facility must develop a uniform assessment tool. The facility may use an acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. No further information provided. TIME PERIOD OF CORRECTION: IMMEDIATE	02310			
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident (R5) was treated with dignity and respect when R5's urinary collection bag was uncovered in the common area of the facility.	02350			

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02350	Continued From page 157 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 February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee was familiar with current minimum assisted living requirements. R5's diagnoses included spastic paresis (increased muscle tension in lower limbs with hyperactive tendon reflexes). R5's Service Plan dated February 5, 2025 (two days after survey initiation), indicated R5 received medication administration, catheter care, positioning/re-positioning, and assistance with bathing, grooming, dressing, laundry, and housekeeping. R5's 90-day Assessment dated June 20, 2023, indicated R5 had an indwelling foley catheter. The assessment further indicated to cover drainage (urinary collection) bag for privacy. On February 5, 2025, at 9:16 a.m., the surveyor observed R5 sitting in R5's wheelchair located in the resident's living room with other residents present. The surveyor observed R5's urinary collection bag uncovered hanging from the side of R5's wheelchair.	02350			

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02350	Continued From page 158 On February 6, 2025, at 2:08 p.m., unlicensed personnel (ULP)-E stated R5's urinary collection bag was always attached to R5's wheelchair and R5 did not like the urinary collection bag covered. ULP-E further stated R5 had a bag to cover R5's urinary collection bag, however, R5 used that bag to store other items on R5's wheelchair. On February 6, 2025, at 3:48 p.m. clinical nurse supervisor (CNS)-D stated CNS-D was unsure if other residents were comfortable with R5's urinary collection bag not being covered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350			
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan.	02410			

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02410	Continued From page 159 Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of four residents (R7) while receiving 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 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 February 3, 2025, at 10:00 a.m., owner (O)-B stated the licensee was familiar with current minimum assisted living requirements. On February 5, 2025, at 9:58 a.m., unlicensed personnel (ULP)-F stated ULP-F completed blood glucose testing training by other ULPs at the facility and ULP-F had not demonstrated blood glucose testing to a registered nurse (RN). On February 5, 2025, at 11:32 a.m., the surveyor observed ULP-F complete a blood glucose test for R7 at the dining room table with two other	02410			

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NAME OF PROVIDER OR SUPPLIER A DAUGHTERS LOVE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 25184 THUNDER ROAD STAPLES, MN 56479		
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02410	Continued From page 160 residents seated at the table. ULP-F cleansed R7's pinky finger on R7's right hand, poked R7's finger, squeezed blood from R7's finger onto the glucometer, and stated to R7 the reading was 106 milligrams (mg)/deciliter (dL). The surveyor did not observe ULP-F ask R7 if R7 wanted to move to a private area to complete the blood glucose test. In addition, the surveyor did not observe ULP-F ask the other two residents sitting at the dining room table if they were okay with a blood glucose test being completed while present at the dining room table. On February 5, 2025, at 12:42 p.m., the surveyor observed ULP-F provide scheduled insulin medication administration to R7. ULP-F entered the living room space area, off the kitchen, where R7 was in a recliner along with four other residents seated in the same room. ULP-F stated to R7 it was time to administer R7's insulin, lifted R7's shirt which exposed R7's abdomen, cleansed R7's upper left quadrant, and administered R7's scheduled insulin. The surveyor did not observe ULP-F ask R7 if R7 wanted to move to a private area to complete the insulin administration. In addition, the surveyor did not observe ULP-F ask the other four residents in the living room area if they were okay observing an insulin administration which exposed R7's abdomen. Immediately following the observation, ULP-F stated ULP-F was not trained or deemed competent on insulin administration by a RN. On February 6, 2025, at 3:48 p.m., clinical nurse supervisor (CNS)-D stated ULPs should have asked a resident about moving to resident a room for privacy prior to administration of a medication or treatment. CNS-D further stated CNS-D was not sure if ULPs should have asked other	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36902	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER A DAUGHTERS LOVE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 25184 THUNDER ROAD STAPLES, MN 56479			
(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
02410	Continued From page 161 residents if they are comfortable observing another resident's medication or treatment administration prior to the ULP completing the administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			

Type: Full
Date: 02/04/25
Time: 11:30:00
Report: 1049251022

Food and Beverage Establishment Inspection Report

Page 1

Location:

A Daughters Love Inc
25184 Thunder Road
Staples, MN56479
Todd County, 77

Establishment Info:

ID #: 0038425
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2182962090
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.

4-700 Sanitizing Equipment and Utensils

4-702.11 **** Priority 1 ****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

THE ESTABLISHMENT IS ONLY WASHING AND RINSING THEIR LARGE PIECES OF EQUIPMENT IN THE TWO-COMPARTMENT SINK. PIC IS INSTRUCTED TO WASH, RINSE AND SANITIZE UTENSILS AND FOOD CONTACT SURFACES BEFORE USE, AFTER CLEANING.

Comply By: 02/04/25

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.

THE ESTABLISHMENT LACKS TEST STRIPS FOR THEIR QUAT SANITIZER. PIC INSTRUCTED TO OBTAIN QUAT TEST STRIPS.

Comply By: 02/04/25

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THE ESTABLISHMENT IS COOKING, COOLING AND THEN RE-HEATING TCS FOODS THE NEXT DAY FOR SERVICE. THE ESTABLISHMENT CURRENTLY HAS A DOMESTIC KITCHEN (NON ANSI). THE ESTABLISHMENT IS INSTRUCTED TO PROVIDE SAME-DAY SERVICE OR PROVIDE ANSI CERTIFIED EQUIPMENT.

Comply By: 02/04/25

Type: Full
Date: 02/04/25
Time: 11:30:00
Report: 1049251022
A Daughters Love Inc

Food and Beverage Establishment Inspection Report

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4-300 Equipment Numbers and Capacities

4-301.12D

MN Rule 4626.0680D Mechanical warewashing equipment in lieu of a 3-compartment sink may be allowed as long as the warewashing equipment is large enough to accommodate the largest piece of equipment to be washed, rinsed and sanitized.

ESTABLISHMENT IS USING A DISH MACHINE TO WASH UTSENSILS AND EQUIPMENT.
HOWEVER, LARGE PIECES OF EQUIPMENT ARE WASHED IN THE 2-COMPARTMENT SINK THAT IS USED FOR HANDWASHING AND FOOD PREP.

Comply By: 02/04/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

THE CEILING PAINT ABOVE THE STOVE IS PEELING. PIC INSTRUCTED TO REPAIR THE CEILING ABOVE THE STOVE.

Comply By: 02/04/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

THE FLOOR HAD ACCUMULATION OF DEBRIS AND THE CEILING VENT WAS DUSTY. PIC INSTRUCTED TO CLEAN THESE AREAS ACCORDINGLY.

Comply By: 02/04/25

Food and Equipment Temperatures

Process/Item: Upright Cooler 1

Temperature: 27 Degrees Fahrenheit - Location: Eggs

Violation Issued: No

Process/Item: Upright Cooler 1

Temperature: 28.5 Degrees Fahrenheit - Location: Biscuits

Violation Issued: No

Process/Item: Upright Cooler 2

Temperature: 38 Degrees Fahrenheit - Location: Lettuce

Violation Issued: No

Process/Item: Upright Cooler 2

Temperature: 39 Degrees Fahrenheit - Location: Yogurt

Violation Issued: No

Process/Item: Upright Cooler 2

Temperature: 39.5 Degrees Fahrenheit - Location: Shredded Cheese

Violation Issued: No

Type: Full
Date: 02/04/25
Time: 11:30:00
Report: 1049251022
A Daughters Love Inc

Food and Beverage Establishment Inspection Report

Page 3

Process/Item: Re-Heating
Temperature: 170 Degrees Fahrenheit - Location: Chicken Enchilada
Violation Issued: No

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

THE INSPECTOR MET WITH THE ESTABLISHMENT REPRESENTATIVE AND NURSE EVALUATOR.

THE DOMESTIC KITCHEN HAS WOOD CUPBOARDS, POPCORN CEILING, TILE LAMINATE FLOORING, LAMINATE COUNTERS, AND PAINTED WALLS.

THE ESTABLISHMENT HAS TWO NON-ANSI REFRIGERATOR/FREEZERS, NON-ANSI STOVE, AND A NON-ANSI DISH MACHINE.

THE ESTABLISHMENT HAS ANSI HOT HOLDING EQUIPMENT.

THE ESTABLISHMENT CURRENTLY HAS A 2-COMPARTMENT SINK THAT IS BEING USED FOR WASHING LARGE PIECES OF EQUIPMENT, WASHING HANDS, AND FOOD PREP. THE PIC IS INSTRUCTED TO EITHER PROVIDE AN ADDITIONAL 3 -COMPARTMENT SINK FOR WAREWASHING LARGE PIECES OF EQUIPMENT OR PROVIDE A DISH MACHINE THAT IS CAPABLE OF FITTING THE LARGEST PIECE OF EQUIPMENT.

THE PIC IS INSTRUCTED TO USE THE 2-COMPARTMENT SINK ONLY FOR HANDWASHING ON ONE SIDE AND FOOD PREP ON THE OTHER SIDE. THE SINK COMPARTMENTS MUST BE LABELED FOR HANDWASHING OR FOOD PREP.

THE DISH MACHINE IS REQUIRED TO REACH A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F TO SANITIZE UTENSILS AND EQUIPMENT PROPERLY.

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.
2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.
3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.
4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

Type: Full
Date: 02/04/25
Time: 11:30:00
Report: 1049251022
A Daughters Love Inc

Food and Beverage Establishment Inspection Report

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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 1049251022 of 02/04/25.

Certified Food Protection Manager Carla Mae Platzer

Certification Number: FM 91395 Expires: 11/05/26

Signed: _____

Establishment Representative

Signed: Stephanie Reynolds

Stephanie Reynolds
Public Health Sanitarian
Fergus Falls
218-332-5179
stephanie.reynolds@state.mn.us

Report #: 1049251022		Food Establishment Inspection Report																															
 Minnesota Department of Health Fergus Falls District 2312 College Way Fergus Falls		No. of RF/PHI Categories Out				1		Date		02/04/25																							
		No. of Repeat RF/PHI Categories Out				0		Time In		11:30:00																							
		Legal Authority MN Rules Chapter 4626						Time Out																									
A Daughters Love Inc		Address 25184 Thunder Road			City/State Staples, MN			Zip Code 56479		Telephone 2182962090																							
License/Permit # 0038425		Permit Holder			Purpose of Inspection Full			Est Type		Risk Category																							
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS																																	
Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item																																	
Mark "X" in appropriate box for COS and/or R																																	
IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS=corrected on-site during inspection R= repeat violation																																	
Compliance Status						COS		R		Compliance Status						COS		R															
Supervision										Time/Temperature Control for Safety																							
1		IN		OUT		PIC knowledgeable; duties & oversight								18		IN		OUT		N/A		N/O		Proper cooking time & temperature									
2		IN		OUT		N/A		Certified food protection manager, duties								19		IN		OUT		N/A		N/O		Proper reheating procedures for hot holding							
Employee Health										20						IN		OUT		N/A		N/O		Proper cooling time & temperature									
3		IN		OUT		Mgmt/Staff;knowledge,responsibilities&reporting								21		IN		OUT		N/A		N/O		Proper hot holding temperatures									
4		IN		OUT		Proper use of reporting, restriction & exclusion								22		IN		OUT		N/A		Proper cold holding temperatures											
5		IN		OUT		Procedures for responding to vomiting & diarrheal events								23		IN		OUT		N/A		N/O		Proper date marking & disposition									
Good Hygienic Practices										24						IN		OUT		N/A		N/O		Time as a public health control: procedures & records									
6		IN		OUT		N/O		Proper eating, tasting, drinking, or tobacco use								Consumer Advisory																	
7		IN		OUT		N/O		No discharge from eyes, nose, & mouth								25		IN		OUT		N/A		Consumer advisory provided for raw/undercooked food									
Preventing Contamination by Hands										26						IN		OUT		N/A		Pasteurized foods used; prohibited foods not offered											
8		IN		OUT		N/O		Hands clean & properly washed								Food and Color Additives and Toxic Substances																	
9		IN		OUT		N/A		N/O		No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed								27		IN		OUT		N/A		Food additives: approved & properly used							
10		IN		OUT		Adequate handwashing sinks supplied/accessible								28		IN		OUT		Toxic substances properly identified, stored, & used													
Approved Source										29						IN		OUT		N/A		Compliance with variance/specialized process/HACCP											
11		IN		OUT		Food obtained from approved source								Risk factors (RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.																			
12		IN		OUT		N/A		N/O		Food received at proper temperature																							
13		IN		OUT		Food in good condition, safe, & unadulterated																											
14		IN		OUT		N/A		N/O		Required records available; shellstock tags, parasite destruction																							
Protection from Contamination																																	
15		IN		OUT		N/A		N/O		Food separated and protected																							
16		IN		OUT		N/A		Food contact surfaces: cleaned & sanitized																									
17		IN		OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food																											
GOOD RETAIL PRACTICES																																	
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.																																	
Mark "X" in box if numbered item is not in compliance																																	
Mark "X" in appropriate box for COS and/or R																																	
COS=corrected on-site during inspection																																	
R= repeat violation																																	
Safe Food and Water						COS		R		Proper Use of Utensils						COS		R															
30		IN		OUT		N/A		Pasteurized eggs used where required								43				In-use utensils: properly stored													
31				Water & ice obtained from an approved source								44				Utensils, equipment & linens: properly stored, dried, & handled																	
32		IN		OUT		N/A		Variance obtained for specialized processing methods								45				Single-use/single service articles: properly stored & used													
Food Temperature Control										46								Gloves used properly															
33				Proper cooling methods used; adequate equipment for temperature control								Utensil Equipment and Vending																					
34		IN		OUT		N/A		N/O		Plant food properly cooked for hot holding						47		X		Food & non-food contact surfaces cleanable, properly designed, constructed, & used													
35		IN		OUT		N/A		N/O		Approved thawing methods used						48		X		Warewashing facilities: installed, maintained, & used; test strips													
36				Thermometers provided & accurate								49				Non-food contact surfaces clean																	
Food Identification										Physical Facilities																							
37				Food properly labled; original container								50				Hot & cold water available; adequate pressure																	
Prevention of Food Contamination										51								Plumbing installed; proper backflow devices															
38				Insects, rodents, & animals not present								52				Sewage & waste water properly disposed																	
39				Contamination prevented during food prep, storage & display								53				Toilet facilities: properly constructed, supplied, & cleaned																	
40				Personal cleanliness								54				Garbage & refuse properly disposed; facilities maintained																	
41				Wiping cloths: properly used & stored								55		X		Physical facilities installed, maintained, & clean																	
42				Washing fruits & vegetables								56				Adequate ventilation & lighting; designated areas used																	
Food Recalls:																																	
Person in Charge (Signature)														Date: 02/05/25																			
Inspector (Signature)														Stephanie Reynolds																			