DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 30, 2022

Administrator
The Brooks on St Paul
2480 St. Paul Road
Owatonna, MN 55060

RE: Project Number(s) SL30837015

Dear Administrator:

On April 15, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the November 19, 2022, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Matthew Heffron

Matthew Heffron, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: matthew.heffron@state.mn.us
Phone: 651-201-4221 Fax: 651-215-5963

HHH

Electronically Delivered

December 29, 2021

Administrator
The Brooks on St. Paul
2480 St. Paul Road
Owatonna, MN 55060

RE: Project Number(s) SL30837015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 19, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Matthew Heffron, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: matthew.heffron@state.mn.us
Phone: 651-201-4186 Fax: 651-215-5963

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30837	A. BUILDING: _____ B. WING _____	11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKS ON ST PAUL	2480 ST. PAUL ROAD OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30837015 On November 16, 17, and 18, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 46 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure the required staffing plan included direct care work schedules showing all work shifts, including days and hours worked. The posted staffing plan inaccurately stated the number of residents for which the staff were providing care. This had the potential to affect the licensee's 46 current residents, staff, and any visitors of the licensee.	0 470		

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0 470	Continued From page 2 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 held an assisted living facility with dementia care license, was licensed for a bed capacity of 50 residents, and had a current census of 46 residents. STAFF POSTING On November 18, 2021, at approximately 9:28 a.m., the facility's posted staffing plan was reviewed. The posting was located on a board near the elevator with a number of other postings. The posting included the morning shift from 6:30 a.m. to 3:00 p.m., the afternoon shift from 2:00 p.m. to 10:00 p.m., 2:30 p.m. to 11:00 p.m., and 3:00 p.m. to 7:00 p.m., and the overnight shift from 10:30 p.m. to 7:00 a.m. The staff members were labeled "RA", the areas the employees were working were labeled "MC" and "AL." The staffing posted indicated that the facility census was 36. The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted in a central location accessible to all	0 470		

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0 470	Continued From page 3 residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, chapter 4626. This had the potential to affect all 46 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 480		

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0 480	Continued From page 4 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated November 17, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care standards for infection	0 510		

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0 510	Continued From page 5	0 510		

control and current recommendations for infection control. The licensee failed to ensure all staff wore personal protective equipment (PPE) in all resident care areas and failed to implement hand hygiene in accordance with current standards.

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:

Lack of Eye Protection/Lack of Masks

The Center for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated September 10, 2021, source control masks and physical distancing are recommended for everyone in a health care setting. It also indicated that in facilities located in counties with substantial or high COVID-19 transmission, health care workers should wear eye protection that covers the front and sides of the face during all patient care encounters.

The Minnesota Department of Health (MDH) COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings document dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical

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0 510	Continued From page 6	0 510		

grade, well-fitting facemask and eye protection. In addition, it instructed HCW with no face-to-face contact with residents to wear a medical-grade, well-fitting facemask.

On November 16, 2021, at approximately 11:15 a.m., during a facility tour, Unlicensed Personnel (ULP)-A was observed in the facility dining area without googles or a mask.

Hand Hygiene (HH)

The licensee failed to ensure staff performed hand hygiene according to the Centers for Disease Control and Prevention (CDC) and MDH guidelines.

The CDC document titled, Interim Infection and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated December 14, 2020, indicated healthcare personnel (HCP) should perform HH before and after all patient contact, contact with potentially infectious material, and before donning and doffing personal protective equipment (PPE), including gloves. The CDC recommended alcohol-based hand sanitizer (ABHS) with 60% to 95% alcohol, or washing hands with soap and water for at least 20 seconds.

On November 17, 2021, at 8:55 a.m., ULP-A did not perform HH before administering medications to a resident. ULP-A donned gloves and touched a garbage bag outside of the resident's room. ULP-A did not perform HH before administering medications to a resident. ULP-A touched each of the resident's pills with gloved hands and administered each pill to the resident.

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0 510	Continued From page 7 On November 17, 2021, at approximately 9:05 a.m., ULP-D was observed assisting R5 dress, while R5 was using the toilet. R5 finished using the bathroom and the dressing activity and ambulated to a recliner. ULP-D handed R5 medications without performing hand hygiene between the dressing assistance in the bathroom and handling the medication. The licensee's Infection Prevention and Control Program dated July 21, 2021, indicated HH is the single most effective way of controlling the spread of infection. The licensee's program also indicated hand washing would be performed between client cares whenever direct physical contact with a client takes place, and the use of gloves does not replace handwashing. No further information was provided. TIME PERIOD FOR CORRECTION : Twenty-one (21) Days	0 510		
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.	0 580		

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0 580	Continued From page 8 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 quality management activity. This had the potential to affect all 46 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 of the residents). The findings include: On November 17, 2021 at 9:18 a.m., administrator (ADM)-E stated the facility had no quality management documentation. The licensee's quality management policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the	0 630		

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0 630	Continued From page 9 person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for one of five residents (R3) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 Findings include: R3 was receiving services from the facility on August 1, 2021. R3 received services including COVID symptom monitoring, TED hose assistance, bathing assistance, medication administation, daily safety checks, and laundry assistance. R3 was prescribed medications, including a blood pressure lowering medication, a blood-thinning medication, a cholesterol lowering medication, and a diuretic.	0 630		

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0 630	Continued From page 10 R3's medical record did not contain an individual abuse protection plan, nor were interventions developed to prevent and/or minimalize potential abuse. On November 18, 2021, at approximately 11:14 a.m., administrator (ADM)-F was asked to provide evidence of an individual abuse prevention plan for R3. ADM-F stated that an individual abuse screening had been performed, but R3 did not have any vulnerabilities. When asked for documentation of the abuse screening stating that R3 had no vulnerabilities, ADM-F stated that such a document could not be obtained. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 630		
0 650 SS=B	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;	0 650		

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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
0 650	Continued From page 11 (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content (proof of current active license, job descriptions, and health screenings) for three of three (ULP-A, RN-B, and ULP-C) employee records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a 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: Unlicensed personnel (ULP)-A's, (ULP)-B's, and registered nurse (RN)-C's records lacked	0 650		

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	30837	A. BUILDING: _____ B. WING _____	11/19/2021

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0 650	Continued From page 12 documentation of a signed job description, and health screenings RN-C's record lacked proof of current active licensure. On November 17, 2021, at 1:00 p.m., administrator (ADM)-A confirmed signed job descriptions and health screenings, including tuberculosis (TB) screenings, were not in the employee records of ULP-A, RN-C, and ULP-D. The licensee's Employee Records policy dated August 1, 2021, indicated personnel records were kept up-to-date, well organized, and complied with assisted living laws and other relevant laws. The licensee's policy also indicated personnel records included TB screening results, current job descriptions, and evidence of current professional licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 650		
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 13 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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included evidence of a facility TB risk assessment, completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, and individual risk assessment of all paid and unpaid employees. Three of three employee files reviewed lacked a TB screening and TB test results (Administrator (ADM)-E, Registered Nurse (RN)-C, and Unlicensed personnel (ULP)-B). This had the potential to affect all 46 residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: FACILITY TB RISK ASSESSMENT	0 660		

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0 660	Continued From page 14 On November 16, 2021, at approximately 11:05 a.m., the licensee was asked to provide the facility TB risk assessment. The document was provided on November 16, 2021, at approximately 2:30 p.m. The assessment was dated November 16, 2021. On November 18, 2021, at approximately 10:48 a.m., ADM-F was asked if the facility TB risk assessment was completed prior to November 16, 2021. ADM-F stated that she believed a facility TB risk assessment had been completed during the summer of 2021, but the assessment could not be located. ADM-F completed the facility TB risk assessment requested on November 16, 2021, after being asked to provide the document. EMPLOYEE SCREENING AND EMPLOYEE TB TESTING RESULTS On November 17, 2021, at 1:00 p.m., ADM-E stated ULP-A's, ULP-B's and RN-C's files tuberculosis (TB) screenings and TB testing results were to be in the employee's respective files but were not. ADM-A provided evidence of TB testing results by requesting the results from the outside facility that had performed the testing, after being alerted the files lacked the documentation. The licensee's Employee Records policy dated August 1, 2021, indicated individual personnel records were kept up-to-date, well organized, and complied with assisted living laws and other relevant laws. The licensee's policy also indicated personnel records included TB screening results. The Minnesota Department of Health (MDH)	0 660		

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0 660	Continued From page 15 guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents.	0 680		

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0 680	Continued From page 16 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and records review, the licensee failed to have a written emergency preparedness plan prominently posted. This had the potential to affect all 46 residents receiving services under the assisted living with dementia care license. 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 November 17, 2021, at 9:00 a.m., during the tour of the licensee's facility, an emergency preparedness plan was not observed posted in a central location. On November 17, 2021, at 9:18 a.m., administrator (ADM)-E verified the emergency preparedness plan was not posted prominently.	0 680		

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0 680	Continued From page 17 The licensee's policy related to posting the written emergency preparedness plan was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

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0 810	Continued From page 18 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 record review, interview, and observation, the licensee failed to provide fire safety and evacuation plans that include 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, and failed to have fire safety and evacuation plans readily available at all times within the facility. This deficient condition had the potential to affect all 46 residents, staff, and visitors the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 November 16, 2021, between approximately 4:05 p.m. and 4:50 p.m., a record review and interview was conducted with the Executive Director (ADM-E) and maintenance person (ULP-G) on employee training of the fire safety and evacuation plans for the facility. The facility's fire safety and evacuation plan did	0 810		

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0 810	Continued From page 19 not include 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. An interview with ADM-E and ULP-G indicated that they were not aware of any procedures to differentiate the response for any of the residents, even though a portion of the facility does contain a locked dementia care unit. A policy was provided, but it lacked the provisions required to verify compliance with MN Statute 144G.45 subd. 2(b)(4). On a facility tour with the ADM-E and ULP-G on November 16, 2021, between approximately 4:50 p.m. and 6:25 p.m., it was observed that there were not any fire safety and evacuation plans posted anywhere in the facility. An interview conducted with ADM-E and ULP-G indicated that both were recently hired, and they were not aware that the fire safety and evacuation plan was not readily available throughout the facility. This deficient condition was visually verified by both ADM-E and ULP-G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760		

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01760	Continued From page 20	01760		

reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure medication was administered as prescribed for one of five residents (R5) with records reviewed. R5's levothyroxine was repeatedly administered later than scheduled, and not in accordance with the manufacturer's recommendation to administer with water only.

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:

On November 17, 2021, at approximately 8:54 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R5. At approximately 9:08 a.m., ULP-D administered multiple medications to R5, including levothyroxine, a thyroid medication. The levothyroxine was scheduled to be administered to R5 at 7:30 a.m. A cup filled with a dark colored liquid was observed next to R5's recliner when the levothyroxine was administered. At

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01760	Continued From page 21	01760		

approximately 9:10 a.m., ULP-D was questioned about R5 receiving levothyroxine later than it is scheduled. ULP-D stated, "I need to get that one changed to later."

R5's medication administration record (MAR) showed R5's levothyroxine medication was scheduled to be administered at 7:30 a.m. for November 2021. The November 2021 MAR documentation indicated R5's levothyroxine was administered on the following dates and times:
9:44 a.m. on November 3, 2021;
9:14 a.m. on November 5, 2021;
8:31 a.m. on November 6, 2021;
9:51 a.m. on November 11, 2021;
9:44 a.m. on November 12, 2021;
8:41 a.m. on November 14, 2021;
8:48 a.m. on November 15, 2021;
8:53 a.m. on November 16, 2021; and
8:58 a.m. on November 18, 2021.

R5's records contained no documentation to indicate why R5's levothyroxine was not administered as prescribed.

The manufacturer's website for Synthyroid, a brand name for levothyroxine, was reviewed. The manufacturer's recommendations for medication administration reads, "Take once a day, every day at the same time before breakfast. Take with only water and on an empty stomach. Wait 30 minutes to 1 hour before eating or drinking anything other than water."

The facility policy on medication administration, titled "Session 5: LIVE Medication Administration and Diabetic Management" was provided. The document includes "medication pass times. One Hour Before and One hour After." On November 18, 2021, at 10:28 a.m. the policy titled "Training

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01760	Continued From page 22 unlicensed personnel for medication, treatment, and therapy administration," was provided. Included in the policy under procedures was the six medication rights, one of which is the right time to administer medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	01760		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk of the physical environment specific to the facility, as required by MN Statute 144G.81 Subd.1 (a). This deficient condition had the potential to affect all 46 residents the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02040		

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02040	Continued From page 23 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 16, 2021, between approximately 4:05 p.m. and 4:50 p.m., a record review and interview was conducted with the Executive Director (ADM)-E and maintenance person (ULP)-G on the hazard vulnerability assessment for the physical environment of the facility. Based on this record review, the licensee did not have a record of a hazard vulnerability assessment for the physical environment on or around the property. An interview conducted with ADM-E and ULP-G indicated that they felt that the hazard vulnerability assessment of the physical environment was encompassed in the facility's Emergency Preparedness policy. A copy of the Emergency Preparedness policy was requested and provided. Review of the provided policy showed that the facility does address the need for a hazard vulnerability assessment and how to create one but failed to prescribe an assessment specific to the physical environment of the facility and did not prescribe mitigation factors specific to the hazards. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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

Type: Full
Date: *11/17/21*
Time: 07:52:58
Report: 8044211372

Food and Beverage Establishment Inspection Report

Location:
The Brooks On St Paul
2480 St. Paul Road
Owatonna, MN55060
Steele County, 74

Establishment Info:
ID #: 0037828
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074665854
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13A ** Priority 2 **

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

No stickers or thermometer for dishwasher.

Comply By: 12/17/21

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

No lactic acid test kit.

Comply By: 11/18/21

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

Food and Beverage Establishment Inspection Report

Rusty shelves in upright cooler.
Comply By: 12/17/21

Surface and Equipment Sanitizers

Hot Water: = at 163.5 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

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

Process/Item: Cold Holding
Temperature: 35.0 Degrees Fahrenheit - Location: Upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.7 Degrees Fahrenheit - Location: Milk in upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.6 Degrees Fahrenheit - Location: Sliced ham in upright
Violation Issued: No

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

Sanitarian comments:

Report reviewed with person in charge, Kelly Lutz.

Report emailed to Jodi Johnson, HRD Health Facility Evaluation Supervisor.

Food and Beverage Establishment Inspection Report

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 8044211372 of 11/17/21.

Certified Food Protection Manager: Kelly Jean Lutz

Certification Number: FM46767 Expires: 11/01/23

Signed: _____
Inspector signed for Kelly

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