Electronically Delivered

March 2, 2022

Administrator
Elmore Assisted Living
202 East North Street
Elmore, MN 56027

RE: Project Number(s) SL31417015

Dear Administrator:

On February 14, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on October 8, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the October 8, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 8, 2021, found not corrected at the time of the February 14, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1650-Service Plan, Implementation, And Revisions T-144g.70 Subd. 4
1890-Prescription Drugs-144g.71 Subd. 20

The details of the violations noted at the time of this follow-up evaluation completed on February 14, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

IMPOSITION OF FINES:

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

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-696-2437.

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

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31417	A. BUILDING: _____ B. WING _____	R 02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 these correction orders are issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL31417015-2 On February 14, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 28, 2021. At the time of the survey, there were 45 active residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (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: No further action required.	{0 480}		
{0 800} SS=D	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: No further action required.	{0 800}		
{01650} SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t	{01650}		

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{01650}	Continued From page 2 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each 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 interview and record review, the licensee failed to ensure resident service plans included all the required content for two of eight residents (R3, R31) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	{01650}		

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{01650}	Continued From page 3	{01650}		

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:

R3
R3's Service Plan dated January 28, 2022, indicated R3 received bathing, grooming, and medication administration.

R3's Service Plan lacked the following:
- a contingency plan that includes:
    - 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
    - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

R31
R31's Service Plan dated February 2, 2022, indicated R31 received bathing and medication administration.

R31's Service Plan lacked the following:
- a contingency plan that includes:
    - 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

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{01650}	Continued From page 4 identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On February 14, 2022, at 2:30 p.m. registered nurse (RN)-Z confirmed the information listed above, and verified the contingency plan should have been completed. The licensee's 6.08 Service Plan policy dated August 1, 2021, noted the service plan would include a contingency plan that includes the names and contact information the resident wishes, if any, to have notified in an emergency or it there is a significant adverse change in the resident's condition; identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and how the facility will support documented resident health care directive decision, if any, including circumstances when emergency medical service are not to be summoned. No further information was provided.	{01650}		
{01890} SS=E	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.	{01890}		

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{01890}	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure time sensitive medications were labeled with the date open for four of four residents (R23, R33, R26, R7). 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 14, 2022, at 9:05 a.m. the 1st floor locked medication cart was reviewed with unlicensed personnel (ULP)-Y. R23's opened Toujeo (insulin) 300 units/milliliter SoloStar pen lacked the date the pen had been opened, and when the pen would expire. In addition, R23's opened NovoLog (insulin) 100 units/milliliter FlexPen lacked the date the pen had been opened, and when the pen would expire. R33's opened NovoLog 100 units/milliliter FlexPen lacked the date the pen had been opened, and when the pen would expire. R26's opened Ozempic (insulin) 2 milligrams/1.5 milliliter pen lacked the date the pen had been opened, and when the pen would expire.	{01890}		

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{01890}	Continued From page 6 On February 14, 2022, at 9:10 a.m. ULP-Y verified the above-named medications were missing the date opened and expiration date marked on them. On February 14, 2022, at 9:20 a.m. the 2nd floor medication cart was reviewed with ULP-W. R7's opened Lantus (insulin) 100 units/milliliter SoloStar pen lacked a date when the pen had been opened, and when the pen would expire. ULP-W confirmed the findings at that time. On February 14, 2022, at 10:07 a.m. registered nurse (RN)-Z stated staff were to initial with date opened and expiration date on all insulin pens. RN-Z indicated staff had been retrained on this expectation a few weeks prior. The manufacturer's instructions for Toujeo revised November 2019, directed to only use pen for up to 56 days after its first use. The manufacturer's instructions for NovoLog revised June 2021, directed once opened, the NovoLog FlexTouch Pen should be thrown away after 28 days, even if it still has insulin left in it. The manufacturer's instructions for Lantus revised December 2020, directed it could be used for up to 28 days. Do not use it after this time. The manufacturer's instructions for Ozempic revised March 2020, directed to dispose after 56 days even if it still has Ozempic left in it. The licensee's 7.11 Medication Storage policy dated August 1, 2021, noted medications that are time sensitive such as those that expire quickly once opened must be marked with date, time,	{01890}		

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{01890}	Continued From page 7 and initials of staff when opened. For example, but not limited to eye drops, ears (sic) drops, inhalers or inhalation medication and insulin. No further information was provided.	{01890}		

Electronically Delivered

January 31, 2022

Administrator
Elmore Assisted Living
202 East North Street
Elmore, MN 56027

RE: Project Number(s) SL31417015

Dear Administrator:

On December 28, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on October 8, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the October 8, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 8, 2021, found not corrected at the time of the December 28, 2021 follow-up evaluation and subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1. - $500.00
0430-Uniform Checklist Disclosure Of Services-144g.40 Subd. 2
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4)
0900-Contract Required-144g.50 Subdivision 1
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2
1640-Service Plan, Implementation, And Revisions T-144g.70 Subd. 4
1650-Service Plan, Implementation, And Revisions T-144g.70 Subd. 4
1820-Prescriptions-144g.71 Subd. 13
1890-Prescription Drugs-144g.71 Subd. 20
1910-Disposition Of Medications-144g.71 Subd. 22
2310-Appropriate Care And Services-144g.91 Subd. 4

The details of the violations noted at the time of this follow-up evaluation completed on December 28, 2021 (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 evaluation completed on December 28, 2021, we identified the following violation(s):

0950-Designation Of Representative-144.50 Subd. 3

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing 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 after 15 days of the receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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

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

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

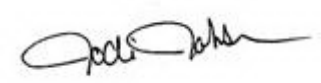
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd.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

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-696-2437 .

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

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
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St. Paul, MN 55101-3879
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{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 these correction orders are issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL31417015-1 On December 27, 2021, through December 29, 2021, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 8, 2021. At the time of the survey, there were 43 active residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 250} SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a	{0 250}		

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{0 250}	Continued From page 1	{0 250}		

provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:
(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;
(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;
(3) performs any act detrimental to the health, safety, and welfare of a resident;
(4) obtains the license by fraud or misrepresentation;
(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;
(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;
(7) interferes with or impedes a representative of the department in contacting the facility's residents;
(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4;
(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;
(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;
(11) refuses to initiate a background study under section 144.057 or 245A.04;
(12) fails to timely pay any fines assessed by the

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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
{0 250}	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to meet the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations, developed and implemented current policies and procedures as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: During the entrance conference on December 27, 2021, at approximately 10:45 a.m. registered nurse (RN)-L stated RN-Z was responsible for and participated in the day-to-day operations. RN-L stated she was familiar with the Assisted Living with Dementia Care licensing rules.	{0 250}		

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{0 250}	Continued From page 3 The licensee attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application; however, the licensee failed to implement the following required policies and procedures: - medication and treatment management. Refer to licensing order at Statute 144G.71, Subd 13. The licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider had managed for two of five residents (R23, R30) with record reviewed. Refer to licensing order at Statute 144G.71, Subd 20. The licensee failed to ensure medications were maintained bearing the original label with legible information for two of two residents (R4, R29) with medication storage reviewed. In addition, the licensee failed to ensure time sensitive medications were labeled with the date open for eight of eight residents (R13, R23, R28, R29, R3, R7, R4, R29). Refer to licensing order at Statute 144G.71, Subd 22. The licensee failed to ensure all required content for disposition of medications was documented for two of two discharged residents (R6, R24) with record review. Twelve (12) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes and Rules were limited or not evident for compliance with sections 144G.08 to 144G.95. No further information was provided.	{0 250}		

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{0 430}	Continued From page 4	{0 430}		
{0 430} SS=A	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide a copy of the Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) with the required content for one of seven residents (R22) with 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 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).	{0 430}		

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{0 430}	Continued From page 5 The findings include: R22 began receiving services under the assisted living licensure on August 1, 2021. R22's Service Plan dated December 27, 2021, indicated R22 received services which included medication administration, bathing, and grooming reminders. R22's record lacked a uniform checklist disclosure of services. On December 29, 2021, community relations manager (CRM)-U indicated she was doing audits on records to ensure contract and related admission packet content requirements were signed prior to uploading them to "the cloud". CRM-U stated not all current residents had been audited yet. CRM-U further verified she had R22 sign the acknowledgment for receiving the UDALSA on December 27, 2021, which was after the surveyor had requested the document. The licensee's 1.04 Uniform Disclosure of Assisted Living Services & Amenities dated August 1, 2021, included: the facility will obtain written acknowledgement from the resident or resident representative or document the reason why an acknowledgement was not obtained.	{0 430}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	{0 480}		

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{0 480}	Continued From page 6 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	{0 680}		

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{0 680}	Continued From page 7 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This had the potential to affect all 43 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, 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 the residents). The findings include: The licensee's red binder titled [licensee] Emergency Preparedness Manual, undated, lacked the following required content: -policy and procedure for tracking staff and residents; -policy and procedure for roles under a 1135 waiver declared by Secretary. On December 27, 2021, at 2:45 p.m. registered nurse (RN)-Z confirmed the emergency	{0 680}		

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{0 680}	Continued From page 8 preparedness manual lacked full development the above required content. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, included: emergency preparedness plan includes policies and procedures designed to align with the LTC (long term care) requirements in Appendix Z. No further information was provided.	{0 680}		
{0 800} SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	{0 800}		

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{0 800}	Continued From page 9 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On facility tour with the Maintenance Manager (MM)-V on December 29, 2021, between approximately 10:30 a.m. and 11:55 a.m., it was observed that the panic bar on the third-floor west side stairwell door had missing pieces to the panic push bar hardware leaving a sharp exposed edge to anyone exiting the area. These sharp edges posed a laceration risk to anyone using this exit door. A large hole was also observed in the exterior wall of room #211. These deficient conditions were visually verified by (MM)-V accompanying on the tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{0 800}		
{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: (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.	{0 900}		

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{0 900}	Continued From page 10 (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 interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for three of eight residents (R22, R20, R21) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	{0 900}		

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{0 900}	Continued From page 11 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R22 R22 began receiving services under the assisted living licensure on August 1, 2021. R22's Service Plan Agreement dated December 27, 2021, indicated R22 received services which included medication administration, bathing, and grooming reminders. R22's record lacked evidence R22 or R22's designee signed an assisted living contract until December 27, 2021, which was 149 days after services were first provided. On December 29, 2021, at 2:57 p.m. community relations manager (CRM)-U indicated she was doing audits on records to ensure contract and related admission packet content requirements were signed prior to uploading them to "the cloud". CRM-U stated not all current residents had been audited yet. CRM-U further verified she had R22 sign the assisted living contract on December 27, 2021, which was after the surveyor had requested the document. R20 R20 started receiving assisted living services on December 14, 2021. R20's Service Plan Agreement dated December 20, 2021, indicated R20 received services which included bathing, grooming, dressing and medication administration. R20's record included an assisted living contract;	{0 900}		

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{0 900}	Continued From page 12 however, it was undated and not signed by facility staff. On December 28, 2021, at approximately 11:50 a.m. RN-L verified R20's contract had been signed by the resident; however, confirmed it was not dated or acknowledged by facility staff. R21 R21 began receiving services under the assisted living licensure on November 23, 2021. R21's Service Plan Agreement dated November 24, 2021, indicated R21 received services which included medication administration, laundry, and housekeeping. R21's record identified a blank contract which was not signed by the resident or the facility. On December 29, 2021, at 2:57 p.m. CRM-U confirmed R21's contract was not signed by the facility or the resident. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 1, 2021, noted when a prospective resident is ready to sign a lease and move in: 1. Fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract. 2. Emphasize to the prospective resident and/or responsible person that assisted living contract is a legal, binding contract. 3. Review the assisted living contract with the prospective resident and/or responsible person and answer any questions they may have. 4. Sign two copies of the contract. 5. Give one copy to the prospective resident	{0 900}		

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{0 900}	Continued From page 13 and/or responsible person and retain one copy for the resident record. No further information was provided.	{0 900}		
0 950 SS=D	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced	0 950		

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0 950	Continued From page 14 by: Based on interview and record review, the licensee failed to offer one of eight residents (R4) the opportunity to identify a designated representative with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's record included a "Master Assisted Living Agreement" dated October 5, 2021. Within that contract was a form which was used to identify legal representative. There was also a section to identify if a resident declined to identify a legal representative on the form. This form was blank and had not been completed by the resident or the staff. On December 29, 2021, at approximately 2:57 p.m. community relations manager (CRM)-U confirmed the legal representative form had not been completed for R4. CRM-U indicated she was doing audits on records to ensure contract and related admission packet content requirements were signed prior to uploading them to "the cloud". CRM-U stated not all current residents had been audited yet. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 1, 2021, noted when a prospective resident is ready to sign a lease	0 950		

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0 950	Continued From page 15 and move in: 1. Fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract. 2. Emphasize to the prospective resident and/or responsible person that assisted living contract is a legal, binding contract. 3. Review the assisted living contract with the prospective resident and/or responsible person and answer any questions they may have. 4. Sign two copies of the contract. 5. Give one copy to the prospective resident and/or responsible person and retain one copy for the resident record. No further information was provided.	0 950		
{01620} SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident	{01620}		

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{01620}	Continued From page 16	{01620}		

of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a change in condition assessment when required for one of four residents (R21).

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).

The findings include:

R21 was admitted to the facility and began receiving services under the assisted living licensure on November 23, 2021.

R21's Service Plan Agreement dated November 24, 2021, indicated R22 received services which included medication administration, laundry, and housekeeping.

R21's Progress Notes identified the following:
-December 2, 2021, at 3:25 p.m. unlicensed personnel (ULP)-W identified at 2:30 p.m. she went into R21's room and R21 stated that she had "passed out 10 minutes earlier". R21 further

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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
{01620}	Continued From page 17 stated "she was standing by the bed when she bent over the bed and then slid to the floor". ULP-W indicated she had the registered nurse (RN) assess. There was no further documentation noted regarding the fall or injuries resulting from the fall. -December 6, 2021, at 1:35 p.m. RN-L documented "resident is complaining of left knee pain nurse notes minor swelling no redness no heat nurse had resident elevate and rotate heat and ice. No falls, no injuries noted nurse reported to doctor". -December 7, 2021, at 2:43 p.m. an order for xrays to the left knee was obtained. -December 9, 2021, at 8:08 a.m. was a late entry for December 8, 2021, at 3:00 p.m. "left knee xrays results mild degenerative arthritis of lateral compartment a small effusion is noted. No fracture, osteonecrosis or dislocation is present if unexplained symptoms persist then a repeat study would be in order." "Nurse explained this to resident and she has decreased pain in her knee today." R21 had a change of condition comprehensive assessment completed on December 6, 2021. On December 28, 2021, at 1:17 p.m. RN-L stated R21 should have had an incident report for the self reported fall on December 2, 2021, and should have had a comprehensive assessment completed. A policy on falls and incident reports was requested, but not provided. No further information was provided.	{01620}		

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{01640}	Continued From page 18	{01640}		
{01640} SS=A	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident service plan included a signature or other authentication by the resident and the licensee to document the agreement on the services to be provided for two of seven residents (R22, R8) with 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 an	{01640}		

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{01640}	Continued From page 19	{01640}		

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:

R22 began receiving services under the assisted living licensure on August 1, 2021.

R22's Service Plan dated December 27, 2021, indicated R22 received services which included medication administration, bathing, and grooming reminders.

R8 began receiving services under the assisted living licensure on August 1, 2021.

During the original survey on October 5, 2021, at approximately 9:35 a.m., ULP-G was observed administering medications to R8.

R8's Service Plan effective August 18, 2021, was signed by her designated representative; however, it was not dated or signed by facility staff.

On December 28, 2021, at 11:48 a.m. registered nurse (RN)-L confirmed R8's service plan was not signed by facility staff and was not dated.

On December 29, 2021, community relations manager (CRM)-U indicated she was doing audits on resident records to ensure contract and related admission packet content requirements were signed prior to uploading them to "the cloud". CRM-U stated not all current residents had been audited yet. CRM-U further verified she had R22 sign the service agreement on December 27, 2021, and confirmed there was no

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{01640}	Continued From page 20 signed service plan for R22 prior to December 27, 2021. The licensee's 6.08 Service Plan policy dated August 1, 2021, noted within 14 days after the date that services are first provided to a resident, the licensee will finalize a written service plan. The service plan and any revisions shall include a signature or other authentication by the facility and the resident or resident's representative, documenting agreement on the services to be provided.	{01640}		
{01650} SS=E	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each 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	{01650}		

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{01650}	Continued From page 21 (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 interview and record review, the licensee failed to ensure resident service plans included all the required content for seven of seven residents (R5, R23, R20, R22, R4, R3, R21) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R5 R5's Service Plan dated August 26, 2021, indicated R5 received services which included bathing, dressing, and medication administration. R5's Service Plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided;	{01650}		

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{01650}	Continued From page 22 - information and a method to contact the facility; - 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 - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R23 R23's Service Plan dated October 7, 2021, indicated R23 received services which included reminders for bathing and grooming, blood sugar checks and medication administration. R23's Service Plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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 - the circumstances in which emergency medical services are not go be summoned	{01650}		

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{01650}	Continued From page 23 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R20 R20's Service Plan Agreement dated December 20, 2021, indicated R20 received services which included bathing, grooming, dressing and medication administration. R20's Service Plan Agreement lacked the following: - a contingency plan that includes: - 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 - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R22 R22's Service Plan Agreement dated December 27, 2021, indicated R22 received services which included medication administration, bathing, and grooming reminders. R22's Service Plan Agreement lacked the following: - a contingency plan that includes: - 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	{01650}		

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{01650}	Continued From page 24 identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R4 R4's service plan indicated R4 received services which included bathing, dressing, transfers, urinary catheter (a tube that collects urine from the bladder and leads to a drainage bag) care, and medication administration. R4's service plan effective October 5, 2021, after it was requested by the surveyor in the original survey. During follow up survey on December 27, 2021, surveyor was provided with R4's Service Plan, which had an effective date August 18, 2021, indicated R4 received services which included bathing, dressing, and medication administration, it was signed by the facility and resident but was not dated. R4's Service Plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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	{01650}		

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{01650}	Continued From page 25 identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3 R3's Service Plan dated October 7, 2021, indicated R3 received services which included bathing, dressing, and medication administration. R3's Service Plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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 - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R21 R21's Service Plan dated November 24, 2021, indicated R21 received services which included	{01650}		

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{01650}	Continued From page 26 medication administration. R21's Service Plan lacked the following: - a contingency plan that includes: - information and a method to contact the facility; and - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On December 28, 2021, at 11:38 a.m. registered nurse (RN)-L indicated there was a "glitch" in their system when completing the admission packet in regards to generating a service plan and service plan agreement which contained the required content. RN-L verified although R20, R21 and R22's service plan agreement had been generated correctly; the form had not been filled out completely to include the required components. The licensee's 6.08 Service Plan policy dated August 1, 2021, noted the service plan would include a schedule and method for the next planned assessment or monitoring, a schedule and method for the next planned monitoring of staff providing services, and a contingency plan that includes the actions to be taken if the scheduled services cannot be provided, information regarding how the resident can contact the facility, how the facility will support documented resident health care directive decisions, if any, including circumstances when emergency medical services are not to be summoned. No further information was provided.	{01650}		

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{01820}	Continued From page 27	{01820}		
{01820} SS=D	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 interview and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider had managed for two of five residents (R23, R30) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R23's record lacked signed prescriber orders for medications to be administered by the licensee. R23's diagnoses included, but were not limited to, type II diabetes mellitus, bipolar disorder, anxiety and alcohol dependence. R23's service plan dated October 7, 2021, indicated the resident received services including medication administration.	{01820}		

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{01820}	Continued From page 28 R23's record contained unsigned interagency transfer orders dated October 8, 2021. R23's Medication Administration Record dated December 2021, listed the medications, times to administer, and staff initials to indicate the medications had been administered. Medications included but were not limited to: aspirin (heart health) 81 milligrams (mg) daily, atorvastatin (for cholesterol) 80 mg daily, buspirone (for anxiety) 5 mg three times daily, dicyclomine (for vomiting and nausea) 10 mg three times daily, Vistaril (for sleep) 50 mg at bedtime, lisinopril 20 mg daily (for blood pressure), melatonin (for sleep) 5 mg at bedtime, metoprolol (for blood pressure) 25 mg daily, naltrexone (for alcoholism) 50 mg daily, pantoprazole (for gastric reflux) 40 mg daily, trazodone (for depression) 50 mg at bedtime, Xarelto (blood thinner) 20 mg daily, and Westab plus (multivitamin) 27-1 mg daily, On December 29, 2021, at 11:35 a.m. registered nurse (RN)-L verified R23's interagency orders were used to reconcile R23's orders. RN-L thought R23's interagency transfer orders had been electronically signed, but upon review verified R23's record lacked signed prescriber orders as required. R30 was admitted to the facility on December 4, 2020, with diagnoses including: adult failure to thrive (when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), chronic pain, weakness, personal history of self harm, chronic obstructive pulmonary disease	{01820}		

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{01820}	Continued From page 29 (COPD) (disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough), generalized anxiety disorder (characterized by uncontrollable worry and anxiety), fibromyalgia (disorder that affects muscle and soft tissue characterized by chronic muscle pain, tenderness, fatigue and sleep disturbances), gastro-esophageal reflux disease (GERD) (chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, the tube connecting the mouth and stomach). R30's service plan dated October 20, 2021, identified she received assistance with bathing, money management, behavior management, dressing, grooming and medication management. R30's December 1, 2021, through December 28, 2021, medication administration record (MAR) identified she had received the following medications; -acetaminophen (pain) 500 mg take two tablets by mouth three times a day; -buspirone (depression) 10 mg take one tablet by mouth twice daily; -duloxetine (depression) 30 mg take one capsule by mouth daily; -duloxetine 60 mg take one capsule by mouth daily; -naproxen (pain) 250 mg take one tablet by mouth every 12 hours; -pantoprazole (GERD) 40 mg take one capsule by mouth twice daily; -Symbicort (COPD) 160-45 inhale two puffs by two months twice daily; -albuterol HFA (COPD) inhale two puffs by mouth every six hours as needed, used on December 8, 2021; -tramadol (pain) 50 mg take one tablet by mouth	{01820}		

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{01820}	Continued From page 30 every six hours as needed for pain, used one-two times daily on 17 of 28 days reviewed; -trazodone (sleep/depression) 50 mg take one to two tablets by mouth at bedtime as needed, used on December 25, 2021; -ventolin (albuterol) (COPD) inhale two puffs by mouth every 4 hours as needed for wheezing, used on December 25, 2021; -diclofenac gel 1% (pain) apply topically four grams to right knee four times daily as needed not used in December 2021; and -ipratropium solution 0.02% (COPD) inhale one ampule via nebulizer twice daily as needed, not used in December 2021. R30's current physician orders were requested and RN-L provided a clinic "visit summary" as her current physician orders. The visit summary identified the encounter was on September 24, 2021; however, it lacked an electronic or hand written signature by a medical provider. The following discrepancies were noted: -Diclofenac Sodium 1 % External Gel apply two-four grams to affected area two-three times a day (MAR states four grams to right knee four times daily as needed); -Ipratropium Bromide 0.02 % Inhalation Solution use one unit dose in nebulizer two times daily (MAR identifies it is as needed); -trazodone 50 mg oral tablet take one tablet at bedtime as needed for sleep (MAR identifies one to two tablets); -Pantoprazole Sodium 40 mg oral tablet take one tablet daily (MAR identifies twice daily); -Naproxen 250 mg oral tablet take one tablet every 12 hours as needed (MAR identifies this as a scheduled medication not as needed); -there are two conflicting orders for duloxetine on the visit summary:	{01820}		

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	31417	A. BUILDING: _____ B. WING _____	R 12/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

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{01820}	Continued From page 31 -duloxetine 30 mg take one tablet by mouth once daily along with a 60 mg tablet. Total daily dose 90 mg per day -duloxetine 60 mg take 3 capsules every morning (MAR identifies 30 mg dose and 60 mg dose daily to equal 90 mg daily). There was no order noted for: -albuterol HFA inhale two puffs by mouth every six hours as needed, used on December 8, 2021. The following orders were consistent with the MAR -ventolin (albuterol) inhale two puffs by mouth every 4 hours as needed for wheezing; -tramadol 50 mg take one tablet by mouth every six hours as needed for pain; -Symbicort 160-45 inhale two puffs by two months twice daily; -acetaminophen 500 mg (milligrams) take two tablets by mouth three times a day; and -buspirone 10 mg take one tablet by mouth twice daily. On December 29, 2021 at approximately 11:35 a.m. registered nurse (RN)-L verified the visit summary for R30 was the current orders. RN-L thought the visit summary had been electronically signed by the provider. Upon review, she confirmed R30 lacked signed prescriber orders as required. The licensee's 7.17 Medication & Treatment Orders policy, dated August 1, 2021, indicated all orders for medications and treatments must be dated and signed by the prescriber, and must be current and consistent with the nursing assessment. No further information was provided.	{01820}		

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{01890} SS=E	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 label with legible information for two of two residents (R4, R29) with medication storage reviewed. In addition, the licensee failed to ensure time sensitive medications were labeled with the date open for eight of eight residents (R13, R23, R28, R29, R3, R7, R4, R29) 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 December 28, 2021, at approximately 8:45 a.m. the 1st floor locked medication cart was reviewed with unlicensed personnel (ULP)-W. R13's opened NovoLog 100 units/milliliter (insulin) pen lacked the date the pen had been	{01890}		

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{01890}	Continued From page 33	{01890}		

opened, and when the pen would expire. In addition, R13's opened Ozempic 2 milligrams/1.5 milliliter (insulin) pen lacked the date the pen had been opened, and when the pen would expire.

R23's opened NovoLog 100 units/milliliter pen lacked the date the pen had been opened, and when the pen would expire.

R28's opened Lantus Solostar 100 units/milliliter (insulin) pen lacked the date the pen had been opened, and when the pen would expire.

On December 28, 2021, at approximately 8:45 a.m. ULP-W confirmed all insulin pens should be dated when opened.

On December 28, 2021, at 10:45 a.m. nurse (RN)-L verified staff were to initial with date opened and expiration date on all insulin pens.

The manufacturer's instructions for NovoLog dated October 22, 2021, directed to dispose after 28 days once opened.

The manufacturer's instructions for Ozempic dated November 2019, directed to dispose after 56 days even if it still has Ozempic left in it.

The manufacturer's instructions for Lantus revised December 2020, directed it could be used for up to 28 days. Do not use it after this time.

On December 28, 2021, at 8:49 a.m. the second floor locked medication cart was reviewed with ULP-G with the following findings:

R29
R29 had an albuterol inhaler without a pharmacy label, in a plastic storage box labeled with her

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{01890}	Continued From page 34 name. R3 R3 had a plastic storage box labeled with her name that contained a basaglar insulin pen. The basaglar pen was not marked with date opened or date it expired. ULP-W stated Basaglar is an evening shift medication and it should have been marked by the staff who opened it. R7 R7 had a plastic storage box labeled with her name that contained Lantus insulin pen. The Lantus pen was not marked with date opened, or the date it expired. ULP-W stated Lantus was an evening shift medication and it should have been marked by the staff who opened it. R4 -R4's fluticasone nasal spray, Bepreve ophthalmic solution, Desitin cream, clotrimazole cream, and ventolin inhaler were stored together in a plastic box labeled with R4's name. There was a thick white substance present on the medication containers. The fluticasone, Bepreve ophthalmic solution, and ventolin inhaler labels were illegible. The fluticasone did not have a cap on the tip of the nose piece to protect it from contamination. ULP-W confirmed the findings. R29 R29 had a plastic storage box labeled with her name that contained an unlabeled albuterol inhaler. On December 28, 1021, at 10:45 a.m. registered nurse (RN)-L confirmed above findings and indicated all medications should be labeled and	{01890}		

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{01890}	Continued From page 35 stored per manufacturer recommendations The manufacturer instructions for Basaglar insulin dated December 5, 2019, instructed to throw away the Pen you are using after 28 days, even if it still has insulin left in it. The facility lacked a policy regarding labeling time sensitive medications with a date when opened. No further information was provided.	{01890}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the	{01910}		

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{01910}	Continued From page 36 licensee failed to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for two of two discharged residents (R6, R24) with record review. 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: R6 R6 was admitted on February 25, 2020, with a diagnosis of malignant neoplasm (cancer) of the liver, and he received medication management services. R6's medication list printed November 26, 2021, and signed by the medical provider, identified he received medication administration of the following medications; hydromorphone (schedule II narcotic pain medication), lorazepam (schedule IV antianxiety medication), nystop powder (for treatment of fungal infection), Trileptal (seizure medication), pantoprazole (gastric reflux), polyethylene glycol (constipation), risperidone (antipsychotic), trihexyphenidyl (treats tremors), Vimpat (seizure medication), and vitamin D3 (supplement).	{01910}		

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{01910}	Continued From page 37 R6's discharge summary dated December 6, 2021, identified he expired at the facility on December 6, 2021. R6's record lacked evidence of a disposition of medications upon death. R24 R24 was admitted August 19, 2021, with a diagnosis of atrial fibrillation (irregular heart beat) and received medication management services. R24's medication list signed by the medical Provider on December 6, 2021, identified the following medications; levothyroxine (thyroid hormone replacement), citalopram (antidepressant), Eliquis (blood thinner), metoprolol (heart medication), simvastatin (cholesterol), tab-a-vite (multivitamin supplement), vitamin B-1 (supplement), and melatonin (sleep). R24's discharge summary dated by the medical provider on December 6, 2021, identified effective December 7, 2021, R24 was moved to another facility closer to his spouse. A Disposition of Medications log was provided; however, did not include the disposition of medications after November 10, 2021. A medication list printed December 7, 2021, identified the following meds with a number hand written at the end of the medication; -levothyroxine tab (tablet) 25 mcg (micrograms) take one tablet by mouth daily - "7" -citalopram tab 10 mg (milligrams) take one tablet by mouth daily - "8" -Eliquis tab 5 mg take one tablet by mouth twice daily - "8+8 16"	{01910}		

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{01910}	Continued From page 38 -metoprolol tartrate tab 50 mg take one tablet by mouth twice daily - "8" -simvastatin tab 20 mg take one tablet by mouth daily - "8" -tab-a-vite take one tablet by mouth daily - "8" -vitamin B-1 100 mg take one tablet by mouth daily "8" -melatonin 3 mg take one tablet by mouth every night at bedtime "8" -acetaminophen 325 mg take two tablets by mouth every four hours as needed "108" The medication list was not authenticated by staff or dated. On December 27, 2021, at approximately 4:00 p.m. registered nurse (RN)-L stated the numbers after the medications listed for R24 were the number of tablets sent with him. RN-L confirmed it lacked authentication, and stated she was unaware which staff completed it. The disposition form was all that was available for R24. There was no disposition of medications completed for R6. The licensee's Medication Disposal policy dated August 1, 2021, identified, "upon disposition, the facility must document in the resident's record the disposition of the expired medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff (including a witness) and other individuals involved in the disposition." No further information was provided.	{01910}		
{02310} SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	{02310}		

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{02310}	Continued From page 39 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 a suitable, and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for one of three residents (R4) with side rails with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted December 10, 2019, and had diagnoses including, but not limited to, multiple sclerosis (a potentially disabling disease of the brain and spinal cord), morbid obesity (a chronic disease that manifests as a steady, slow, progressive increase in body weight), neurogenic bladder a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and fibromyalgia (A disorder that affects muscle and soft tissue characterized by chronic muscle pain, tenderness, fatigue and sleep disturbances).	{02310}		

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{02310}	Continued From page 40 R4's service plan indicated R4 received bathing, dressing, transfers, urinary catheter (a tube that collects urine from the bladder and leads to a drainage bag) care, and medication administration. R4's service plan was dated as effective October 5, 2021, after it was requested by the surveyor in the original survey. During the follow up survey on December 27, 2021, the surveyor was provided with R4's Service Plan, which had an effective date of August 18, 2021, indicated R4 received services including bathing, dressing, and medication administration. The service plan was signed by the facility and the resident, but was not dated. R4's siderail assessment dated November 23, 2021, identified R4 had difficulty with balance, trunk control, and sitting on the edge of the bed. R4 used the siderail to aid in positioning. R4 expressed a desire to have the side rails on her bed for safety and comfort and did not want them released while she was asleep. The recommendations were: -siderails are indicated and serve as an enabler to promote independence; -the client has expressed a desire to have side rails raised while in bed; -siderails do not appear to be indicated at this time; and -resident will be able to sit up and have more independence. R4's comprehensive assessment dated December 28, 2021, identified "half bed rails: uses bed rails for bed mobility, rails are not used to restrict the resident's ability to get in or out of bed".	{02310}		

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{02310}	Continued From page 41 On December 27, 2021, at 2:15 p.m. R4's bilateral half bedrails were observed. The bedrail on the right was against the wall, and was slightly loose. It moved approximately 1-2 inches back and forth. The left sided bed rail was in the lowered position. The end 2 bars were detached from the middle section of the rail and were bent down and around the middle section of the rail on the outside of the rail. The area that had detached had a sharp exposed raw edge of metal on the outside. RN-L entered the room to collect a urinalysis. Surveyor showed her the siderail and she stated she had been unaware that the siderail was broken. RN-L asked R4 if she could remove the rail, and R4 consented and further stated she did not want the bed rail as she did not use it anyway, since it got in the way with her use of her electric chair. RN-L stated her expectation was staff were to report the broken side rail to her and to maintenance. She would have to interview staff about the side rail and whether R4 used the side rail, because she was not always accurate in her statements. On December 27, 2021, at 4:10 p.m. RN-L stated siderail assessments would be completed quarterly moving forward. She was unsure if the damage to the siderail was from R4 running into it with her electric chair, but that was a possibility. There was no where in the siderail assessment that identified assessing the siderail for safety regarding dimensions and other functional concerns, such as a broken siderail. The licensee's 6.28 Side Rails policy dated August 1, 2021, indicated staff would determine if the side rail is considered to be safe, regardless of who owns or is supplying the side rail. The policy noted staff will determine if the side rail is used consistent with manufacturer's directions,	{02310}		

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{02310}	Continued From page 42 installed securely and maintained in good operating condition; be aware of "wobbly" side rails, and side rail design consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. The FDA, A Guide to Bed Safety, revised April 2010, included the following information: When bed rails are used, perform an on-going assessment of the patient's physical and mental status and closely monitor high-risk patients. The FDA also identified; Reassess the need for using bed rails on a frequent, regular basis. No further information was provided.	{02310}		

Electronically Delivered

November 19, 2021

Administrator
Elmore Assisted Living
202 East North Street
Elmore, MN 56027

RE: Project Number(s) SL31417015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 8, 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 Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31417	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

(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 ORDERS In accordance with Minnesota Statutes, section 144G.08 to 144G.95, the correction orders have been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project #SL31417015 On October 4, 2021 through October 8, 2021, surveyors of this department's staff visited the above Assisted Living provider and the following correction orders were issued. At the time of the survey there were 46 residents recieving services under the Assisted Living with Dementia Care License. In addition, on October 4, 2021 through October 8, 2021, the Minnesota Department of Health conducted an investigation of complaint HL31417002C. The following correction orders are issued for HL31417002C, tag identification 0630 and 3000. .	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	

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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports was employed as required. This resulted in an immediate correction order on October 8, 2021, at approximately 1:52 p.m. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 4, 2021, at approximately 11:42 a.m. during entrance conference, registered nurse (RN)-Z identified self as the licensed assisted living director (LALD). There was no evidence of current assisted living director licensure noted in RN-Z's employee file. On October 8, 2021, at approximately 12:15 p.m. RN-Z verified she did not have her LALD license	0 110		

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0 110	Continued From page 2 yet, but she had applied for it. On October 8, 2021, at approximately 12:26 p.m. RN-Z printed off proof of the LALD application, which identified the applicant's resume and employment verification were missing; therefore, the LALD application was not completed. The licensee's Employee Records policy dated August 1, 2021, noted the employee records would include evidence of current professional licensure if required. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate. On October 8, 2021, at approximately 4:20 p.m. the provider presented proof of LALD licensure, and an email was received from Minnesota Board of Executives for Long Term Serivces and Supports indicated LALD licensure had been approved. The immediacy was removed as confirmed by document review by evaluation supervisor on October 8, 2021.	0 110		
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in	0 250		

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0 250	Continued From page 3 this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category.	0 250		

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0 250	Continued From page 4 (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to meet the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations, developed and implemented current policies and procedures as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 October 4, 2021, at approximately 11:42 a.m., registered nurse (RN)-Z confirmed she was responsible for and participated in the day-to-day operations. RN-Z stated she was familiar with the Assisted Living with Dementia Care licensing rules. The licensee attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application; however, the facility failed to implement the following required policies and procedures: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency	0 250		

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0 250	Continued From page 5 evaluations of staff; - orientation to and implementation of the assisted living bill of rights; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Center for Disease Control and Prevention standards; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. Refer to licensing order at Statute 144G.42, Subd 6, and 626.557, Subd 3. The licensee failed to report to Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R1) with record reviewed. In addition, the licensee failed to implement individual abuse prevention plan with the required content for one of four residents (R5) with records reviewed. Refer to licensing order at Statute 144G.61, Subd 2 (b and c). The licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for three of three unlicensed personnel (ULP-I, ULP-B, ULP-C) with records reviewed. Refer to licensing order at Statute 144G.63, Subd 2. The licensee failed to ensure employees received orientation to include the required content for five of five employees (ULP-B, ULP-C, ULP-I, and licensed practical nurse (LPN)-M) with records reviewed. Refer to licensing order at Statute 144G.64 (a). The licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for four of four	0 250		

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0 250	Continued From page 6 employees (ULP-I, ULP-B, ULP-C, and LPN-M) with records reviewed. Refer to licensing order at Statute 144G.90, Subd. 1. The licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents and information about how to make a complaint was provided to the residents and a written acknowledgement received for six of six residents (R3, R5, R1, R8, R9, R4) with records reviewed. Refer to licensing order at Statute 144G.91, Subd 13. The licensee failed to ensure privacy in double occupancy room for 10 of 46 residents. Refer to licensing order at Statute 144G.41, Subd 3. The licensee failed to follow guidance related to COVID-19. Refer to licensing order at Statute 144G.42, Subd 9. The licensee failed to develop and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment. In addition the facility failed to ensure one of five employees (ULP-C) had a TB symptom screen and 2-step Mantoux with records reviewed. Refer to licensing order at Statute 144G.71, Subd 3. The licensee failed to ensure the RN completed annual medication reassessments for three of three residents (R3, R1, R4) receiving medication management services. Refer to licensing order at Statute 144G.71, Subd 5. The licensee failed to develop an individualized medication management record with the required	0 250		

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0 250	Continued From page 7 content for two of four residents (R3, R7) with records reviewed. Refer to licensing order at Statute 144G.71, Subd 13. The licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider had managed for one of eight residents (R7) with records reviewed. Refer to licensing order at Statute 144G.71, Subd 14. The licensee failed to renew prescriptions at least every 12 months for four of five residents (R3, R1, R4 and R8) with records reviewed. Refer to licensing order at Statute 144G.71, Subd 20. The licensee failed to date time sensitive medications with a date when opened for two of two residents (R3, R7) who received medication management services. Refer to licensing order at Statute 144G.71, Subd 22. The licensee failed to ensure all required content for disposition of medications was documented in one of one discharged resident (R2). Refer to licensing order at Statute 144G.72, Subd 6. The licensee failed ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R7) receiving treatments. Refer to licensing order at Statute 144G.62, Subd 4. The licensee failed to ensure a RN conducted direct supervision of staff performing a delegated task within 30 days of providing services for three of three unlicensed personnel (ULP-B, ULP-C, and ULP-I) with records reviewed.	0 250		

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0 250	Continued From page 8 Thirty-three (33) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes and Rules were limited or not evident for compliance with sections 144G.08 to 144G.9999. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a copy of the	0 430		

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0 430	Continued From page 9 Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) with the required content for six of six residents (R5, R3, R8, R9, R4, R1) with 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 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: R5, R3, R8, R9, R4, and R1's records lacked a uniform checklist disclosure of services. R5's undated Service Plan indicated R5 received services which included medication administration, cueing and prompting for meals, bathing, dressing,and grooming assistance. On October 5, 2021, at approximately 12:03 p.m., unlicensed personnel (ULP)-T was observed to cue and assist R5 to sit down for meals. R5's record lacked evidence the UDALSA was received by R5. R3's undated Service Plan indicated R3 received services, which included bathing, grooming, and medication administration. On October 5, 2021, at approximately 11:55 a.m., ULP-N was observed to administer R3 an insulin injection. R3's record lacked evidence the UDALSA was received by R3 until September 14, 2021 (45 days later).	0 430		

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0 430	Continued From page 10 R8's record lacked a service plan. On October 5, 2021, at approximately 9:35 a.m., ULP-G was observed to administer medications to R8. R8's record lacked evidence the UDALSA was received by R8. R9's record lacked a service plan. On October 5, 2021, at approximately 9:45 a.m., ULP-G was observed to administer medications to R9. R9's record lacked evidence the UDALSA was received by R9. R4's Service Plan, effective date October 5, 2021, indicated R4 received services which included bathing, dressing, transfers, urinary catheter (a tube that collects urine from the bladder and leads to a drainage bag) care, and medication administration. R4's UDALSA was signed on October 5, 2021, the same day it was requested by the surveyor (65 days after receiving assisted living services). R1's undated Service Plan indicated R1 received services which included assistance with medication administration, bathing, dressing, grooming, dining, bed mobility, transfers, and toileting assistance. On October 5, 2021, at approximately 9:35 a.m., ULP-G and ULP-S were observed providing cares to R1 when checking, changing, and repositioning R1.	0 430		

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0 430	Continued From page 11 R1's record lacked evidence the UDALSA was received by R1. On October 6, 2021, at approximately 10:09 a.m., RN-Z confirmed R5, R3, R8, R9, R4, R1, and all other residents receiving services under the license had not received the UDALSA. The licensee's 1.04 Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) policy dated August 1, 2021, noted the facility would provide a UDALSA to prospective residents prior to signing an Assisted Living contract. The policy further identified the facility would obtain written acknowledgement from the resident or resident representative, or document the reason why an acknowledgement was not obtained. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 12 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This 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 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 October 4, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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	31417	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 510	Continued From page 13 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This deficient practice had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee failed to ensure employees in direct contact with residents were wearing appropriate personal protective equipment (PPE) as per the Centers for Disease Controls (CDC) and Minnesota Department of Health (MDH) guidelines.	0 510		

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0 510	Continued From page 14	0 510		

PPE
On October 4, 2021, at 3:28 p.m., unlicensed personnel (ULP)-T and ULP-S walked out of R6's room wearing a medical grade face mask but no eye protection. Both ULP-S and ULP-T verified they did not have eye protection on and should when providing personal cares to R6.

On October 5, 2021, at 9:29 a.m., ULP-G was observed to administer oral medications, nasal spray and eye drops to R8. ULP-G was wearing her face mask below her nose and was wearing a face shield during the medication administration process. ULP-G stated that when they had no cases of COVID-19 in the facility, they (staff) stopped wearing face shields. ULP-G stated when they had someone test positive, they started wearing them again.

On October 5, 2021, at 9:30 a.m. on the 3rd floor, one resident was eating breakfast and another sitting on the couch watching TV. ULP-T walked by the living room area wearing only a medical grade mask. Eye protection was observed on top of ULP-T's head.

On October 5, 2021, at 10:10 a.m., ULP-T was observed pushing R6 in a wheelchair with the protective eye wear on top of her head. At 10:13 a.m., ULP-T was observed walking into R5's room without eye protection on and closed the door.

On October 5, 2021, at 10:20 a.m., job coach (JC)-D was observed wearing a cloth mask and no eye protection. JC-D was observed walking over to where residents were sitting on a couch in the living room and speaking with them.

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0 510	Continued From page 15 On October 5, 2021, at 11:52 a.m., dietary aide (DA)-E was observed carrying meal trays into resident rooms. DA-E was wearing a face mask but no eye protection. On October 5, 2021, at 12:03 p.m., DA-H was observed pouring juice and giving residents their napkins and silverware. DA-H was wearing a cloth mask but no eye protection. During this same time, DA-F was observed delivering plated meals to residents at the table. DA-F was wearing a medical grade face masks but no eye protection. On October 6, 2021, at 9:20 a.m., registered nurse (RN)-Z stated all staff were supposed to wear a medical grade face mask and eye protection when performing resident cares or when in resident care areas, which included the common living and dining areas on each unit. The licensee staff failed to isolate immediately and wear proper PPE while providing care to a resident (R11) who returned from the hospital and was to be isolated for 14 days. Licensee staff also failed to disinfect medical equipment after use on a quarantined resident. On October 7, 2021, at 1:03 p.m., R11 returned from the hospital. There was no signage or PPE supplies observed outside R11's room. R11 and R4 were in a double occupancy room. The privacy curtain was not pulled across the room and neither resident was wearing a mask. Licensed practical nurse (LPN)-M entered the room wearing a face mask; her eye protection was on her head. LPN-M performed a COVID test on R11 and informed R11 she would be	0 510		

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moved to a private room. After exiting the room, LPN-M performaed no hand hygiene. R11 exited the room, wheeling herself through a common area, passed two other residents and into the bathroom. R11 then asked R9 to assist her to find soap in her bag. R11 and R9 were not wearing a facemask. R9 attempted to find the soap in a bag attached to the back of R11's wheelchair. Community relations manager (CRM-U), while wearing a mask but no eye protection, intervened and assisted R11 back to her room. RN-K, while wearing mask but no eye protection, and ULP-G, while wearing a mask but no eye protection, entered room and began moving R11's personal items to another room. ULP-G then entered the room with a blood pressure cuff, stethoscope, thermometer, and oximeter. She used them to check R11's vital signs. She exited the room carrying those items and brought them to the medication cart. ULP-G opened drawers on the medication cart and placed the items in the cart. When questioned about cleaning the items, ULP-G stated that she would clean them later. ULP-G continued to administer medications to other residents. Observations continued for approximately one hour, and the items had not been cleaned. R11 was assisted to the private room 213. Maintenance staff (M)-O and M-P were moving items into room 213, which were occupied by R11 at the time. M-O was wearing a mask and eye protection. M-P was wearing a mask below the nose, barely covering the mouth, but no eye protection. They entered and exited room 213 and other rooms several times, but no hand hygiene was performed. RN-Z returned to the floor with a PPE storage bin and signage outside of room 213. Throughout the observation, none of the staff were wearing gowns or gloves when providing cares or while in close contact with R11.

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0 510	Continued From page 17 At approximately 2:00 p.m., while wearing a cloth face mask but no eye protection, DA-H brought water into resident rooms. She approached R9, handed her water, and talked to her briefly before continuing to deliver water to resident rooms. Screening The facility failed to assure staff and visitors were screened prior to entering the facility. Facility forms "Elmore COVID-19 Screening" dated October 4, 2021, through October 7, 2021, were reviewed and had sections for staff /resident/visitor name, temperature, respiratory symptoms/cough/chest pain, travel, visitor phone number and initials for screener. The form had the following findings: -October 4, 2021, seven of the entries had the staff/visitor name, temperature, and initials for screener; however, it lacked answers to the respiratory symptoms and travel; -October 5, 2021, one entry had the staff/visitor name, temperature, and initials for screener; however, it lacked answers to the respiratory symptoms and travel; -October 6, 2021, six of the entries had the staff/visitor name, temperature, and initials for screener; however, it lacked answers to the respiratory symptoms and travel; -October 7, 2021, four of the entries had the staff/visitor name, temperature, and initials for screener; however, it lacked answers to the respiratory symptoms and travel. On October 7, 2021, at 11:57 a.m., RN-L stated the staff COVID-19 screenings were completed by staff at the beginning of the shift. The screenings should be completed with a temperature and all questions answered. The	0 510		

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0 510	Continued From page 18 screenings were collected and placed in a box. No audit or review had been completed. The Minnesota Department of Health Infection Prevention and Control: COVID-19 electronic guidance for infection prevention and control in health care settings dated August 2, 2021, indicated MDH recommends eye protection for all health care workers (HCW) in all resident care areas and when providing direct care. In addition, MDH recommends all HCW wear a facemask regardless of vaccination status when in the health care settings. The Centers for Disease Control and Prevention (CDC) COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated September 10, 2021, indicated eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. The facility's 8.03 Cleaning of Shared Medical Equipment policy dated August 1, 2021, noted all reusable resident care equipment is routinely cleaned, and when appropriate, disinfected, before and after reuse. Common shared resident care equipment may include: -Stethoscopes -Glucometers not limited to individual resident use -Mechanical lifts -Etc. All equipment must be cleaned immediately if visibly soiled, and immediately after use on residents with contact precautions regardless of cleaning schedule.	0 510		

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0 510	Continued From page 19 The licensee's 6.09 Employee and Contractor Screening policy dated March 1, 2020, noted each day a log will be kept for employee and contractor screening. The licensee lacked policies related to PPE for COVID-19. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 620		

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0 620	Continued From page 20 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included, but were not limited to, deaf non-speaking, dementia with behavioral disturbance, depression, and bipolar disorder. R1's Vulnerability Assessment/Abuse Prevention Plan dated June 9, 2021, indicated R1 was oriented to person and place, but has had a cognitive decline in the past year. R1 will display behaviors towards staff including: holding onto their hands, attempts to bite staff, hitting, and kicking. The plan indicated R1 was susceptible to abuse due to an inability to communicate related to diagnoses of deaf & non-speaking. On August 28, 2021, at approximately 6:00 a.m., R1 was sitting in his wheelchair when unlicensed personnel (ULP)-A, ULP-B, and ULP-C entered the room to provide care. R1 bit ULP-A during cares, causing a break in the skin. On August 28, 2021, at 6:15 a.m. the licensee's Resident Incident Report identified R1 bit ULP-A's hand during cares which required ULP-A to seek medication attention. The report did not identify the incident was reported as suspected maltreatment as the investigation indicated there was a previous history R1 biting staff. R1's progress note dated August 28, 2021, at 11:31 a.m. identified R1 bit ULP-A and broke the skin. ULP-A went to the Emergency Department for evaluation. The progress note indicated R1's behaviors had recently increased and nothing	0 620		

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0 620	Continued From page 21 further was mentioned. The licensee's investigative report dated September 10, 2021, identified on August 28, 2021, ULP-A hit R1, restrained his hands, slapped him across the face, made lewd gestures and called him names. The incident was not reported until September 9, 2021, when ULP-C came forward and reported the incident to licensed practical nurse (LPN)-M and registered nurse (RN)-L. R1's progress note dated September 14, 2021, at 4:49 p.m. late entry for September 13, 2021, identified R1's family member was notified of a report was submitted to MAARC. On October 4, 2021, at 11:42 a.m., RN-Z stated the licensee followed the vulnerable adult reporting requirements if alleged abuse or neglect was suspected and would report to MAARC. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting Policy dated August 1, 2021, identified the licensee educated staff about how to report suspected maltreatment internally and to the MAARC. Upon hire and annually all staff will be trained on identifying and reporting suspected maltreatment of vulnerable adults. Staff who suspect maltreatment of a resident or who has knowledge of abuse are to take immediate action to protect, or keep safe, the resident affected. Next, they are to contact the clinical nurse supervisor if medical attention needed and/or contact the assisted living director. The assisted living director or clinical nurse will confirm suspicion of maltreatment and contact the MAARC, such report must be made no later than 24 hours after first suspected. Staff reporting will not be	0 620		

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0 620	Continued From page 22 retaliated against for making a good faith report of suspected maltreatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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 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 facility failed to ensure development of an individual abuse prevention plan with the required content for one of four residents (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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	0 630		

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0 630	Continued From page 23 only occasionally). The findings include: R5's diagnosis included, but was not limited to, dementia (memory disorder). R5's Service Plan, undated, indicated R5 received services which included medication administration, cueing and prompting for meals, bathing, dressing,and grooming assistance. R5's Vulnerability, Safety & Risk Assessment dated July 21, 2021, identified R5's areas of vulnerability in the following areas: orientation to time, place and person; ability to give accurate information consistently; anxiety/depression/mental illness; unable to follow directions consistently; and unable to report abuse or neglect. R5's assessment indicated the abuse prevention plan with identified interventions that were needed was based on the assessment and should be incorporated into R5's care plan; however, R5's Task Assigned/Plan of Care last updated August 4, 2021, did not include interventions despite notation of the above areas of vulnerability. On October 7, 2021, at 12:47 p.m., registered nurse (RN)-K confirmed R5's care plan did not address the above noted areas of risk and should have based on the vulnerability assessment. The licensee's 6.05 Individual Abuse Prevention Plan policy dated August 1, 2021, noted the plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults; b. there person's risk of abusing other	0 630		

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0 630	Continued From page 24 vulnerable adults; and c. statement of the specific measure to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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, 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 a facility TB risk assessment. The licensee failed to ensure one of five employees	0 660		

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0 660	Continued From page 25 (unlicensed personnel (ULP)-C) had a TB symptom screen and 2 step Tuberculin Skin Test (TST) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: TB RISK ASSESSMENT During the entrance conference on October 4, 2021, at approximately 11:42 a.m. with registered nurse (RN)-Z, a surveyor requested to review the facility TB risk assessment. On October 6, 2021, at 10:09 a.m., RN-Z brought in a blank TB risk assessment. At this time, the surveyor verified with RN-Z the facility TB risk assessment was blank and was not completed as required. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, noted the facility will maintain a current community TB risk assessment that will be updated annually using the data and form provided by the Minnesota Department of Health (MDH). SCREEN FOR ACTIVE/LATENT TB ULP-C's employee record showed ULP-C had a start date of August 1, 2021. ULP-C's employee record lacked evidence to indicate ULP-C had a current Tuberculosis (TB) Screening or TST prior to starting employment.	0 660		

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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
0 660	Continued From page 26 The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, noted the facility will: -conduct screening of new staff for active signs of TB using the Baseline TB Screening Tool for Health Care Worker's (HCW); -new staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCW's; -no staff will be permitted to begin work where the work involved sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented; and -staff TB screening results will be kept in each employee medical file. 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	0 680		

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	31417	A. BUILDING: _____ B. WING _____	10/08/2021

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0 680	Continued From page 27 (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an all-hazards emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 October 4, 2021, at approximately 11:42 a.m. with registered nurse (RN)-Z, a surveyor requested to review the licensee's emergency preparedness plan. On October 6, 2021, at 10:09 a.m., RN-Z brought in a packet of papers identified as the emergency	0 680		

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0 680	Continued From page 28 preparedness and the Appendix Z plan. The licensee's plan provided to the surveyors was a copy of the Centers for Medicare & Medicaid Services (CMS) Updated Guidance for Emergency Preparedness-Appendix Z of the State Operations Manual (SOM) dated March 26, 2021. On October 6, 2021, at approximately 10:09 a.m., RN-Z verified the facility did not have a plan to include any of the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire extinguishers in accordance with Minnesota State Fire Code as required by MN Statute 144G.45 subd.2(a)(2). This had the	0 790		

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0 790	Continued From page 29 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: During the facility tour with Executive Chef (EC)-Q and Maintenance Manager (MM)-V between 10:45 a.m. and 12:55 p.m. on October 5, 2021, it was observed that a fire extinguisher was missing from the cabinet on the 3rd floor west side by the exit stairwell. Upon further observation, the fire extinguisher was found located behind the locked exit stairwell door on the floor of the stair landing. This deficient practice was visually verified by EC-Q and MM-V accompanying on the facility tour. Fire extinguishers are required by State Fire Code to be readily available and mounted no less than 4" from the floor. No further information was provided. 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,	0 800		

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0 800	Continued From page 30 systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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 as required by MN Statute 144G.45, subd.2(a)(4). 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 findings include: During the facility tour with Executive Chef (EC)-Q and Maintenance Manager (MM)-V between 10:45 a.m. and 12:55 p.m. on October 5, 2021, it was observed that there was mold present in the 1st floor sanitation closet, the 1st floor maintenance closet by Room 103 on "Sunbeam Road", and all of the 2nd floor maintenance closets on the west side. These rooms containing mold also contain furnaces and air handling equipment which can distribute the mold to the areas this equipment serves, posing	0 800		

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0 800	Continued From page 31 an air quality issue for residents and staff of these areas. These deficient practices were visually verified by the EC-Q and MM-V accompanying on facility tour. It was also observed that a portion of the sheetrock ceiling in the 1st floor maintenance room had collapsed from a possible water leak, exposing the wood floor joists from the floor above. As evidenced by the fire caulking, the sheetrock ceiling was part of a required fire barrier to protect the floor above. Compromised sheetrock fire barriers compromise the ability to contain a possible fire from getting into the floor system and increasing rate of fire spread. This deficient practice was visually verified by the EC-Q and MM-V accompanying on facility tour. It was also observed that the 3rd floor door by the elevator that leads the west side memory care area had missing pieces to the panic push bar hardware leaving a sharp exposed edge to anyone exiting the area. A similar condition was observed on the 3rd floor west side exit stairwell from this same area. These sharp edges pose a laceration risk to anyone exiting the area at either of these listed exits. These deficient practices were visually verified by the EC-Q and MM-V accompanying on the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	0 820		

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0 820	Continued From page 32 assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain the physical environment in a condition that does not create a distinct hazard to residents and staff as required by MN Statute 144G.45, subd.2(g). 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), 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 facility tour with Executive Chef (EC)-Q and Maintenance Manager (MM)-V between 10:45 a.m. and 12:55 p.m. on October 5, 2021, it was observed that there was an electric space heater with the cover missing with loose fiberglass insulation up against it in the Sunbeam Room bathroom maintenance room creating a	0 820		

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0 820	Continued From page 33 fire risk. This deficient condition was visually verified by EC-Q and MM-V accompanying on facility tour. It was also observed that the gas water heater in the Sunbeam Room bathroom maintenance room had a disconnected chimney, which was allowing carbon monoxide to be exhausted into the room instead of to the exterior of the building. This deficient condition was visually verified by EC-Q and MM-V accompanying on facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 900 SS=F	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: (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	0 900		

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0 900	Continued From page 34 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 assisted living contract prior to providing assisted living services for six of six residents (R3, R5, R4, R8, R9, R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R3, R5, R4, R8, R9 and R1 all began receiving assisted living services on August 1, 2021, and their records lacked evidence of a written	0 900		

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0 900	Continued From page 35 assisted living contract prior to providing assisted living services as required. R3's Service Plan, undated, indicated R3 received services which included bathing, grooming, and medication administration. On October 5, 2021, at approximately 11:55 a.m., unlicensed personnel (ULP)-N was observed administering an insulin injection to R3. R3's record lacked evidence R3 or R3's designee signed an assisted living contract until September 14, 2021, which was 45 days after services were first provided. E-mail communication from the facility's community living coordinator (CLC)-J identified an email was sent to R3's designee on September 9, 2021, at 1:12 p.m. reading, "in accordance with Assisted Living guidelines effective August 1st 2021, we have updated our current Housing with Service Contract signed at admission. Attached please find updated documentation. I have included two attachments, the first is the updated packet in its entirety. The second titled "Signature Pages" include only paperwork requiring signatures or additional information. Please sign and return "Signature Pages" at your earliest convenience." R5's Service Plan, undated, indicated R5 received services which included medication administration, cueing and prompting for meals, bathing, dressing,and grooming assistance. On October 5, 2021, at approximately 12:03 p.m., ULP-T was observed to cue and assist R5 to sit down for meal. R5's record lacked evidence R5 or R5's designee signed an assisted living contract until August 23,	0 900		

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0 900	Continued From page 36 2021, which was 23 days after services were first provided. R4's face sheet printed October 5, 2021, identified she was admitted on December 10, 2019. R4's service plan effective date October 5, 2021, indicated R4 received services which included bathing, dressing, transfers, urinary catheter (a tube that collects urine from the bladder and leads to a drainage bag) care, and medication administration. On October 8, 2021, at 10:30 a.m., ULP-G was observed to empty R4's urinary catheter. R4's record lacked evidence R4 or R4's designee signed an assisted living contract until it was requested by the surveyor on October 5, 2021, which was 65 days after services were first provided. R8's record lacked a service plan. On October 5, 2021, at approximately 9:35 a.m., ULP-G was observed administering medications to R8. R8's record lacked evidence R8 or R8's designee signed an assisted living contract. E-mail communication from the facility's community living coordinator (CLC)-J identified an email was sent to R8's designee on August 25, 2021, at 2:41 p.m. indicating, "in accordance with Assisted Living guidelines effective August 1st 2021 we have updated our current Housing with Service Contract signed at admission. Attached please find updated documentation. I have included two	0 900		

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0 900	Continued From page 37 attachments, the first is the updated packet in its entirety. The second titled "Signature Pages" include only paperwork requiring signatures or additional information. Please sign and return "Signature Pages" at your earliest convenience." The e-mail was resent on October 6, 2021, at 9:53 a.m. R9's record lacked a service plan. On October 5, 2021, at approximately 9:45 a.m., ULP-G was observed to administer medications to R9. R9's record lacked evidence R9 or R9's designee received and signed an assisted living contract. On October 13, 2021, at 11:12 a.m., RN-Z stated the licensee did not have a signed contract for R8 and R9. RN-Z confirmed there was not a signed contract for R4 prior to October 5, 2021. R1's service plan, undated and unsigned, indicated R1 received services which included medication administration, housekeeping, physical assistance with bathing, dressing, grooming, transferring, and toileting. On October 5, 2021, at approximately 9:35 a.m., ULP-G and ULP-S were observed checking, changing, and repositioning R1. On October 5, 2021, at approximately 4:00 p.m., RN-Z stated R1's son had not returned a signed contract back to the facility. On October 6, 2021, at approximately 10:54 a.m., CLC-J confirmed a contract should be developed	0 900		

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0 900	Continued From page 38 or executed for the licensee's current residents or upon move in as required. CLC-J verified no contracts were completed for residents by August 1, 2021, because they were awaiting revisions from their corporate office. The licensee's policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01370 SS=E	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment	01370		

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01370	Continued From page 39 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 facility failed to ensure training and competency evaluations were completed as required prior to providing direct care to residents for three of three unlicensed personnel (ULP-I, ULP-B, ULP-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01370		

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01370	Continued From page 40 ULP-I's employee record lacked evidence to indicate the employee completed training and/or practical skills evaluations as required in the following areas: -care and use of hearing aids; -standby assistance techniques and how to perform them; -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 appropriate boundaries between staff and resident and the resident's family; and -procedures to utilize in handling various emergency situations. ULP-I began providing assisted living services on August 1, 2021. On October 4, 2021, at 2:22 p.m., ULP-I was observed interacting with R1. ULP-I's employee record contained a Home Health Aide Competency Evaluation dated January 16, 2020, and January 28, 2021, which listed numerous training and demonstration topics; however, the form lacked information related to the above required training. ULP-B had a start date of February 15, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B's employee record lacked evidence to indicate the employee completed training and/or practical skills evaluations as required in the following areas: - documentation requirements for all services	01370		

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	31417	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

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01370	Continued From page 41 provided; - appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; dressing and assisting with toileting. - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - understanding appropriate boundaries between staff and residents and the resident's family; -procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices ULP-C had a start date of August 6, 2021. ULP-C's employee record lacked evidence to the employee completed training and/or practical skills evaluations as required in the following areas: - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating;	01370		

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01370	Continued From page 42 - preparation of modified diets as ordered by a license health professional; - communication skills that include preserving the dignity of the client and showing respect for the resident and the resident's preferences, cultural background, and family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On October 8, 2021, at approximately 10:56 a.m., registered nurse (RN)-Z verified all of the information listed above. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, noted required content for ULP training included appropriate and safe techniques in personal hygiene and grooming, including care and use of hearing aids, standby assistance techniques and how to perform them, 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01370		
01380 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn	01380		

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01380	Continued From page 43 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care to residents for two of three unlicensed personnel (ULP-B, ULP-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B had a start date of February 15, 2021, under the comprehensive home care license, and	01380		

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01380	Continued From page 44 began providing assisted living services on August 1, 2021. ULP-B's employee record lacked evidence to indicate the employee completed training and competency evaluation as required in the following areas: - basic knowledge of body functioning and changes in body functioning, injuries, and other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and - range of motioning and positioning ULP-C had a start date of August 6, 2021. ULP-C's employee record lacked evidence to indicate the employee completed training and competency evaluation as required in the following areas: - observation, reporting, and documenting of resident status; and - 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 the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning and - administering medications or treatments as required. On October 8, 2021, at approximately 10:56 a.m., registered nurse (RN)-Z verified ULP-B and ULP-C's file lacked the required content noted above.	01380		

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01380	Continued From page 45 The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, noted required content for ULP training and competency evaluation included 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 the resident, recognizing physical, emotional, cognitive, and developmental needs of the resident, safe transfer techniques and ambulation, range of motioning and positioning, and administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01380		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the	01440		

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01440	Continued From page 46 interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services to residents for three of three unlicensed personnel (ULP-I, ULP-B, ULP-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-I began providing assisted living services for the provider on August 1, 2021; however, ULP-I began working for the provider on December 16, 2019, under the comprehensive home care license. ULP-I's employee record lacked evidence a RN conducted direct supervision of the employee performing a delegated task within 30 days the employee had first performed the	01440		

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01440	Continued From page 47 delegated task for residents. On October 4, 2021, at 2:22 p.m., ULP-I stated she provided medication administration to residents. ULP-B started employment on February 15, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B's records lacked evidence the RN conducted direct supervision of the ULP-B performing a delegated task within 30 days after the employee had first performed the delegated task for residents. ULP-C began providing assisted living services for the provider on August 8, 2021. ULP-C's records lacked evidence the RN conducted direct supervision of ULP-C performing a delegated task within 30 days the employee first performed the delegated task for residents. The facility's schedule identified during the time period August 23, 2021, through September 5, 2021, ULP-B and ULP-C were scheduled and worked overnight shifts. During the course of their work, ULP-B and ULP-C completed delegated tasks as assigned. On October 6, 2021, at approximately 2:59 p.m., RN-K stated the supervision of staff performing a delegated task should be done within 30 days, but verification of this could be missing from their employee files. No further information was provided.	01440		

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01440	Continued From page 48 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the	01470		

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01470	Continued From page 49 facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure employees received orientation to include the required content for four of four employees (unlicensed personnel (ULP)-I, ULP-C, ULP-B, and licensed practical nurse (LPN)-M) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01470		

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01470	Continued From page 50 situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-I, ULP-B, ULP-C, and LPN-M's employee records lacked evidence to indicate the employees had received the required orientation content. ULP-I began providing assisted living services for the facility on August 1, 2021. ULP-I's record lacked evidence of receiving orientation to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure On October 4, 2021, at 2:22 p.m., ULP-I was observed interacting with R1. ULP-B began providing assisted living services	01470		

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01470	Continued From page 51 for the facility on August 1, 2021. ULP-B's record lacked evidence to indicate the employees received the required orientation content: - an overview of Home Care/Assisted Living statutes; - review of provider's policies and procedures; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and - principles of person-centered planning/service delivery ULP-C began providing assisted living services for the facility on August 6, 2021. ULP-C's record lacked evidence of receiving orientation to include the following required content: - an overview of Home Care/Assisted Living statutes; - handling emergencies and using emergency services; - home care/Assisted Living bill of rights; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and	01470		

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01470	Continued From page 52 Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -principles of person-centered planning/service delivery. LPN-M began providing assisted living services for the facility on August 1, 2021. LPN-M's record lacked evidence of receiving orientation to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure On October 8, 2021, at approximately 10:56 a.m., RN-Z confirmed all of the information above. RN-Z stated only a few of the company's employees had completed the required	01470		

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01470	Continued From page 53 orientation. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, identified employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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 by: Based on observation, interview and record	01540		

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01540	Continued From page 54	01540		

review, the licensee failed to ensure four of four direct-care staff (unlicensed personnel (ULP)-I, ULP-B, ULP-C, and licensed practical nurse (LPN)-M) completed the required amount of dementia care training in the required time frame with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2021.

ULP-I began providing assisted living services to residents on August 1, 2021.

On October 4, 2021, at 2:22 p.m., ULP-I was observed interacting with R1.

ULP-I's employee record did not contain documention ULP-I completed the required eight (8) hours of training on the specific dementia care topics within 80 working hours of ULP-I's hire date.

ULP-B began providing assisted living services to residents on August 1, 2021.

ULP-B's employee record did not contain documentation ULP-B completed the required

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01540	Continued From page 55 eight (8) hours of training on the specific dementia care topics within 80 working hours of ULP-B's hire date. ULP-C began providing services to residents on August 6, 2021. ULP-C's employee record did not contain documentation ULP-C completed the required eight (8) hours of training on the specific dementia care topics within 80 working hours of ULP-C's hire date. LPN-M began providing assisted living services to residents on August 1, 2021. LPN-M's employee record did not contain documention LPN-M completed the required eight (8) hours of training on the specific dementia care topics within 80 working hours of LPN-M's hire date. On October 8, 2021, at approximately 11:01 a.m., registered nurse RN-Z confirmed all of the information listed above. The licensee's 5.03 Dementia Training policy dated August 1, 2021, noted direct care employees of assisted living with dementia care licensed facilities will complete eight (8) hours of initial training within 80 hours of the employment start date. Employees may not provide direct care until the training is complete unless another employee who has completed the initial training is present to provide assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		

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01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a change in condition assessment was completed for one of one resident (R4) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01620		

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01620	Continued From page 57 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4's service plan indicated R4 received services which included bathing, dressing, transfers, urinary catheter (a tube that collects urine from the bladder and leads to a drainage bag) care, and medication administration. R4's service plan was dated as effective October 5, 2021, after it was requested by the surveyor. R4's progress notes dated August 28, 2021, at 1:02 p.m. identified "resident was going out the handicap door with her motorized wheelchair when she accidentally bumped into another resident hitting the other residents right ankle with her wheelchair, both residents stated that it was an accident and not intentional." R4's progress notes dated September 25, 2021, at 9:37 p.m. identified "resident's knee gave out and she was lowered to the floor using stand aid. Stated that her MS is flaring. Lift and 2 assist to get her into bed. Denied any increase in pain. Stated that she has pain in her back and knees before and unchanged with being lowered on to the floor." Incident reports were requested for the two documented incidents related to R4; no incident reports, assessments, investigation or interventions were provided. On October 8, 2021, at approximately 10:30 a.m., RN-L confirmed there were no incident reports, assessments, investigations, or follow up interventions for the noted incidents wtih R4.	01620		

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01620	Continued From page 58 RN-L further indicated she would expect the unlicensed personnel (ULPs) would inform the nurse on duty, who would then initiate an incident report, complete an assessment, and notify the unit manager. RN-L stated a comprehensive assessment should have been completed after each of the incidents, staff should have continued to monitor for injuries after the incidents, and the doctor should have been notified. A policy on falls and incident reports was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=C	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	01640		

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01640	Continued From page 59 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident service plan included a signature or other authentication by the resident and the licensee to document the agreement on the services to be provided for six of six residents (R3, R5, R1, R8, R9, R4) with 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 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: R3's Service Plan, undated, indicated R3 received services, which included bathing, grooming, and medication administration. R3's Service Plan lacked a signature or other authentication by the licensee documenting agreement on the services to be provided. On October 5, 2021, at approximately 11:55 a.m., unlicensed personnel (ULP)-N was observed administering R3 an insulin injection. R5's Service Plan, undated, indicated R5 received services, which included medication administration, cueing and prompting for meals, bathing, dressing,and grooming assistance. R5's	01640		

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01640	Continued From page 60 Service Plan lacked a signature or other authentication by the licensee documenting agreement on the services to be provided. On October 5, 2021, at approximately 12:03 p.m., ULP-T was observed to cue and assist R5 to sit down for meal. On October 6, 2021, at 1:55 p.m., registered nurse (RN)-L confirmed both R3 and R5's service plans lacked a signature by the licensee as required. R1's Service Plan Agreement dated October 5, 2021, lacked a signature or other authentication by the licensee documenting the agreement on the services to be provided. R1's Service Plan indicated R1 received services which included assistance with bathing, behavior monitoring and interventions, grooming, medication administration, bed mobility, transfers, and toileting. On October 5, 2021, at approximately 9:35 a.m., ULP-G and ULP-S were observed to check, change, and reposition R1. On October 6, 2021, at approximately 10:55 a.m., community living coordinator (CLC)-J identified there was not a signed service plan agreement for R1. CLC-J further stated revisions still needed to be made. On October 7, 2021, at approximately 8:20 a.m., RN-L stated no resident service plan agreements were printed, mailed out, or signed prior to October 5, 2021. R8's record lacked a service plan.	01640		

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01640	Continued From page 61 On October 5, 2021, at approximately 9:35 a.m., ULP-G was observed administering medications to R8. R8's record lacked evidence an assisted living contract, which included the service plan, was signed by R8 or R8's designee. E-mail communication from CLC-J identified an email was sent to R8's designee on August 25, 2021, at 2:41 p.m. reading, "in accordance with Assisted Living guidelines effective August 1st 2021 we have updated our current Housing with Service Contract signed at admission. Attached please find updated documentation. I have included two attachments, the first is the updated packet in its entirety. The second titled "Signature Pages" include only paperwork requiring signatures or additional information. Please sign and return "Signature Pages" at your earliest convenience." The e-mail was resent on October 6, 2021, at 9:53 a.m. R9's record lacked a service plan. On October 5, 2021, at approximately 9:45 a.m., ULP-G was observed administering medications to R9. R9's record lacked evidence of a service plan signed by R9 or R9's designee. R4's service plan effective date October 5, 2021, indicated R4 received services which included bathing, dressing, transfers, urinary catheter (a tube that collects urine from the bladder and leads to a drainage bag) care, and medication administration. On October 8, 2021, at 10:30 a.m., ULP-G was observed emptying R4's urinary catheter.	01640		

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01640	Continued From page 62 R4's service plan was signed on October 5, 2021, after it was requested by the surveyor. On October 6, 2021, at 10:03 a.m., RN-Z stated the licensee did not have a signed service plan for R8 and R9. RN-Z confirmed there was no signed service plan for R4 prior to October 5, 2021. The licensee's 6.08 Service Plan policy dated August 1, 2021, noted the service plan would have a signature or other authentication by the facility and the resident or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01650 SS=E	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each 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;	01650		

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01650	Continued From page 63 (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 facility failed to ensure resident service plans included all the required content for three of four residents (R3, R5, and R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3's Service Plan, undated, indicated R3 received services, which included bathing, grooming, and medication administration.	01650		

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01650	Continued From page 64 R3's Service Plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On October 5, 2021, at approximately 11:55 a.m., unlicensed personnel (ULP)-N was observed administering R3 an insulin injection. R5's Service Plan, undated, indicated R5 received services, which included medication administration, cueing and prompting for meals, bathing, dressing,and grooming assistance. R5's Service Plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 65 On October 5, 2021, at approximately 12:03 p.m., ULP-T was observed to cue and assist R5 to sit down for the meal. R4's Service Plan effective October 5, 2021, indicated R4 received services which included bathing, dressing, transfers, urinary catheter (a tube that collects urine from the bladder and leads to a drainage bag) care, and medication administration. R4's Service Plan was signed on October 5, 2021, after it was requested by the surveyor. R4's Service Plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On October 6, 2021, at 1:55 p.m., registered nurse (RN)-L confirmed the information listed above. The licensee's 6.08 Service Plan policy dated August 1, 2021, noted the service plan would include a schedule and method for the next planned assessment or monitoring, a schedule and method for the next planned monitoring of staff providing services, and a contingency plan	01650		

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01650	Continued From page 66 that includes the actions to be taken if the scheduled services cannot be provided, information regarding how the resident can contact the facility, how the facility will support documented resident health care directive decisions, if any, including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication re-assessments for three of three residents (R3, R1, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more	01710		

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than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R3's diagnosis included, but was not limited to, pica (an eating disorder in which people eat non-food items).

R3's Service Plan, undated, indicated R3 received services which included bathing, grooming, and medication administration.

R3's prescriber's orders printed October 5, 2021, at 4:20 p.m. included, but was not limited to, a mild pain reliever, one anti-anxiety, one anti-depressant, one anti-convulsant, one for mood disorder, one for allergies, one for cholesterol, two medications for blood pressure, three vitamins, and two insulins.

On October 5, 2021, at approximately 11:55 a.m., unlicensed personnel (ULP)-N was observed administering R3 an insulin injection.

R3's record lacked documentation of an annual medication re-assessment. The most recent medication assessment was dated November 25, 2019.

R1's diagnoses included, but were not limited to, deaf non-speaking, depression, hypertension (high blood pressure), dementia with behaviors, bipolar disorder, and Type 2 Diabetes with neuropathy (nerve damage to the feet and hands).

R1's Service Plan, undated, indicated R1 received services, which included medication

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administration, bathing, grooming, dressing, dining assistance to set up and assist as needed, and behavioral management.

R1's record lacked signed prescriber orders for medications.

R1's medication administration record (MAR) for the time period October 1 through October 4, 2021, identified medications were administered to R1 by facility staff. Medications administered during that time period included: acetaminophen (for pain) 1000 milligrams (mg) twice daily, aspirin (stroke preventative) 81 mg daily, citalopram (for bipolar) 20 mg daily, Divalproex (for mood) 250 mg three times a day, Divalproex (for mood) 125 mg three times a day from October 5 through October 18, 2021, Donepezil (for dementia) 5 mg daily, furosemide 40 mg twice daily, gabapentin (for depression) 200 mg three times daily, lisinopril 5 mg daily, lorazepam (for anxiety) 0.5 mg daily, meclizine 50 mg daily in the morning, meclizine 25 mg daily in the evening, pantoprazole (gastric upset) 40 mg daily, Risperdal injection (for bipolar) 25 mg every two weeks, senna (stool softener) 8.6 mg two tabs daily, trazodone 100 mg daily, and lorazepam 0.5 mg as needed every six hours.

R1's record lacked documentation of an annual medication re-assessment. The most recent medication assessment was dated October 23, 2019.

R4's face sheet printed October 5, 2021, identified she had the following diagnoses: adult failure to thrive (a state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments),

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gastro-esophageal reflux disease (occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach), morbid obesity (severely over weight), neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), retention of urine (bladder does not empty all the way), optic atrophy (a condition that often causes slowly worsening vision), fibromyalgia (a disorder that affects muscle and soft tissue characterized by chronic muscle pain, tenderness, fatigue and sleep disturbances), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), multiple sclerosis (a disabling disease of the brain and spinal cord), obstructive sleep apnea (when the upper airway becomes blocked repeatedly during sleep, reducing or completely stopping airflow), hypercholesterolemia (high cholesterol accumulation in the body), spinal stenosis (a condition where spinal column narrows and compresses the spinal cord), mild neurocognitive disorder (a decline primarily in intellectual function due to disease of the brain).

R4's Medication Assessment Form dated December 11, 2019, identified R4 was unable to take medications independently and received medication administration services. R4 did not have an annual medication reassessment.

R4's record lacked prescriber's orders for some of the medications administered by the facility.

R4's Service Plan effective date October 5, 2021, indicated R4 received services, which included bathing, dressing, transfers, urinary catheter (a tube that collects urine from the bladder and leads to a drainage bag) care, and medication administration. R4's Service Plan was signed on

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ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

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01710	Continued From page 70 October 5, 2021, after it was requested by the surveyor. R4's October 1 through October 4, 2021, MAR indicated the following medication had been administered as scheduled, without current signed physician orders: -amantadine 100 mg twice daily (control movement problems); -amphetamine/dextroamphetamine 10 mg daily (attention deficit disorder medication); -atorvastatin 20 mg daily (cholesterol); -baclofen 10 mg 2 tablets three times a day (muscle spasms); -buspirone 10 mg 2 tablets twice daily (anti-depressant); -calcium 500 mg daily (supplement); -citalopram 20 mg daily (anti-depressant); -clotrimazole cream twice daily (to treat rash); -cranberry capsule 500 mg twice daily (supplement); -Desitin cream apply twice daily (to treat rash); -fluticasone 50 mcg nasal spray 1 spray each nostril twice daily (allergies); -furosemide 20 mg every morning (decrease excess fluid in the body); -gabapentin 300 mg twice daily (chronic pain); -oxybutynin 10 mg daily (urinary retention); -pantoprazole 20 mg daily (gastric reflux); -polyethyline glychol 17 grams daily (constipation); and -venlafaxine 150 mg daily (antidepressant) The licensee's 7.01 Medication Management-Assessment Monitoring & Reassessment policy dated August 1, 2021, noted the facility would reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and,	01710		

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01710	Continued From page 71 at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to	01730		

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01730	Continued From page 72 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management record with the required content for two of four residents (R3, R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 4, 2021, at approximately 11:42 a.m. registered nurse (RN)-Z confirmed the licensee provided medication management services to the residents at the facility. R3's diagnosis included, but was not limited to,	01730		

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01730	Continued From page 73 diabetes. R3's Service Plan, undated, indicated R3 received services which included bathing, grooming, and medication administration. R3's prescriber's orders printed October 5, 2021, at 4:20 p.m. included, but were not limited to, a mild pain reliever, one anti-anxiety, one anti-depressant, one anti-convulsant, one for mood disorder, one for allergies, one for cholesterol, two medications for blood pressure, three vitamins, and two insulins. On October 5, 2021, at approximately 11:55 a.m., unlicensed personnel (ULP)-N was observed administering R3 an insulin injection. R3's record lacked a service plan to include a written statement of the medication management services R3 received. R3's medication management record did not include the following: - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services On October 7, 2021, at approximately 12:41 p.m., RN-K confirmed R3's medication management plan did not include all the required content. R7's diagnosis included, but was not limited to, type 2 diabetes. R7's prescriber's orders, printed October 5, 2021, at 4:20 p.m. included, but were not limited to, one oral diabetic, two insulins, one eye supplement, one supplement for sleep, and one bipolar medication.	01730		

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01730	Continued From page 74 On October 5, 2021, at approximately 12:02 p.m., ULP-G was observed administering R7 an insulin injection. R7's record lacked a service plan to include a written statement of the medication management services R7 received. R7's medication management record did not include the following: - documentation of specific resident instructions relating to the administration of medications; and - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services On October 7, 2021, at approximately 8:20 a.m., RN-L confirmed R7 did not have a service plan. On October 7, 2021, at approximately 12:41 p.m., RN-K confirmed R7's medication management plan did not include all the required content. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, noted the resident's medication management record would include procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section	01820		

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01820	Continued From page 75 151.01, 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 review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for one of eight residents (R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R7's record lacked prescriber's orders for some of the medications administered by the facility. R7 was admitted for services on October 21, 2020. R7's October 1 through October 4, 2021, MAR indicated the following medication was administered as scheduled without current signed physician orders: -Novolog (insulin) injectable flexpen 4 units subcutaneous three times daily with meals for blood glucose >100 before breakfast or dinner; -preservision capsules AREDS (eye vitamin) one capsule twice daily;	01820		

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01820	Continued From page 76 -quetiapine (for mental/mood disorder) 25 mg one tablet daily; -Lantus (insulin) solos injectable 7 units daily; and -melatonin (supplement for sleep) 6 mg daily at bedtime On October 6, 2021, at approximately 2:34 p.m. RN-L confirmed R7's records lacked prescriber orders for the above listed medications. RN-L stated the physician rounding had access to see the medications in their computer system and will dictate "reviewed"; however, the individual medication orders are not listed on the dictation. RN-L further stated the pharmacy gets the prescription and verified there were not any in the resident records. RN-L included as of October 6, 2021, a medication list had been printed and signed by the rounding nurse practitioner for R7. The licensee's 7.20 Medication & Treatment Orders policy dated August 1, 2021, indicated the RN was responsible for assuring that current, authorized prescriber orders for medications administered by the staff are kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=E	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152.	01830		

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01830	Continued From page 77 This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to renew prescriptions at least every 12 months for four of five residents (R3, R1, R4 and R8) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R3 R3's record lacked an annual renewal of prescriber orders for medications. R3 was admitted on November 21, 2019. R3's Service Plan, undated, indicated the resident received services which included bathing, grooming, and medication administration. R3's Medication/Treatment Therapy Management Plan dated March 5, 2021, indicated the resident received medication management services which included medication administration. On October 5, 2021, at approximately 11:55 a.m. unlicensed personnel (ULP)-N was observed to administer R3 an insulin injection. R3's medication administration record (MAR),	01830		

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01830	Continued From page 78 dated October 1 through October 4, 2021, included, but was not limited to the following medications: - atorvastatin (for cholesterol) 80 mg daily- last order dated November 21, 2019. - calcium citrate 315 mg with vitamin D 200 units (supplement) twice daily- last order dated November 21, 2019. - cetirizine (for allergies) 10 mg daily- last order dated June 18, 2020. - Novolog (insulin) 6 units subcutaneously three times daily with meals- last order dated February 19, 2020 - Novolog sliding scale of 2 units for every 50 points greater than 150 mg/deciliter three times daily- last order dated February 19, 2020. - propranolol (for blood pressure) 20 mg daily- last order dated November 21, 2019. - multivitamin (supplement) daily- last order dated November 21, 2019. - vitamin D3 (supplement) 25 micrograms daily- last order dated November 21, 2019. - Cortaid maximum strength apply to affected areas twice daily as needed for hives- last order dated July 2, 2020. - nitroglycerine 0.4 mg sublingually every 5 minutes for chest pain as needed maximum 3 tablets within 15 minutes- last order dated November 21, 2019. - polyethylene glycol 3350 mix 17 grams in 4-8 ounces of water or juice and drink daily as needed for constipation- last order dated November 27, 2019. On October 6, 2021, at approximately 2:34 p.m. registered nurse (RN)-L confirmed R3's record lacked prescriber orders for the above listed medications within the past year. RN-L stated the physician rounding has access to see the medications in their computer system, and will	01830		

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01830	Continued From page 79 dictate "reviewed"; however, the individual medication orders are not listed on the dictation. RN-L further stated the pharmacy gets the prescription and verified there were not any on site in the resident record. RN-L further indicated as of October 6, 2021, a medication list had been printed and signed by the rounding nurse practitioner for R3. R1 R1's record lacked prescriber's orders for renewal of some of the medications administered by the facility. R1 began receiving services on October 23, 2019. R1's October 1 through October 4, 2021, MAR indicated the following medication had been administered as scheduled, without documented renewal of prescribed medication: acetaminophen (for pain) 1000 milligrams (mg) twice daily, aspirin (stroke preventative) 81 mg daily, citalopram (for bipolar disorder) 20 mg daily, divalproex (for mood) 250 mg three times a day, divalproex (for mood) 125 mg three times a day from October 5 through October 18, 2021, donepezil (for dementia) 5 mg daily, furosemide 40 mg twice daily, gabapentin (for depression) 200 mg three times daily, lisinopril 5 mg daily, lorazepam (for anxiety) 0.5 mg daily, meclizine 50 mg daily in the morning, meclizine 25 mg daily in the evening, pantoprazole (gastric upset) 40 mg daily, Risperdal injection (for bipolar disorder) 25 mg every two weeks, senna (stool softener) 8.6 mg two tabs daily, Trazodone 100 mg daily, and lorazepam 0.5 mg as needed every six hours.	01830		

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01830	Continued From page 80 R4 R4's face sheet printed October 5, 2021 identified she was admitted on December 10, 2019. R4's record lacked annual renewal of prescriber's orders for some of the medications administered by the facility. R4's service plan effective October 5, 2021, indicated the resident received services which included bathing, dressing, transfers, urinary catheter (a tube that collects urine from the bladder and leads to a drainage bag) care, and medication administration. R4's service plan was signed on October 5, 2021, after it was requested by the surveyor. R4's October 1 through October 4, 2021, MAR indicated the following medications had been administered as scheduled, without current signed physician orders: -amantadine 100 mg twice daily (control movement problems); -amphetamine/dextroamphetamine 10 mg daily (attention deficit disorder medication); -atorvastatin 20 mg daily (cholesterol); -Baclofen 10 mg 2 tablets three times a day (muscle spasms); -buspirone 10 mg 2 tablets twice daily (anti-depressant); -calcium 500 mg daily (supplement); -citalopram 20 mg daily (anti-depressant); -clotrimazole cream twice daily (to treat rash); -cranberry capsule 500 mg twice daily (supplement); -Desitin cream apply twice daily (to treat rash); -fluticasone 50 mcg nasal spray 1 spray each nostril twice daily (allergies); -furosemide 20 mg every morning (decrease	01830		

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01830	Continued From page 81 excess fluid in the body); -gabapentin 300 mg twice daily (chronic pain); -oxybutynin 10 mg daily (urinary retention); -pantoprazole 20 mg daily (gastric reflux); -polyethyline glychol 17 grams daily (constipation); and -venlafaxine 150 mg daily (antidepressant) R8 R8's record lacked annual renewal of prescriber's orders for some of the medications administered by the facility. R8 was admitted for services on February 11, 2020. R8's record lacked a service plan. On October 5, 2021, at approximately 9:35 a.m. ULP-G was observed to administer medications to R8 which included unidentified oral medications, artificial tears both eyes, and fluticasone nasal spray into both nostrils. R8's October 1 through October 4, 2021, MAR indicated the following medications had been administered as scheduled, without current signed physician orders: -acetaminophen 500 mg 2 tablets three times a day; -artificial tears 1 drop in both eyes twice daily; -aspirin 81 mg daily; -atorvastatin 40 mg daily (cholesterol); -benztropine 1 mg twice daily (abnormal muscle movements); -capsaicin cream twice daily (pain); -citalopram 20 mg daily (anti-depressant); -clotrimazole twice daily; -divalproex 500 mg 4 tablets at bedtime (seizure medication, also used for mood);	01830		

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01830	Continued From page 82 -fluticasone 2 sprays in each nostril daily; -furosemide 20 mg daily; -gabapentin 600 mg three times a day; -haloperidol 10 mg twice daily (anti-psychotic); -levothyroxine 100 mcg daily (thyroid hormone replacement); -loratadine 10 mg daily (allergies); -metformin 500 mg 2 tablets twice daily (diabetes); -calcium 500 mg twice daily (supplement); -pentoxifylline 400 mg three times a day (used to improve blood flow); -senna plus 8.6/50 mg twice daily (constipation); and -Trazodone 100 mg every bedtime. (anti-depressant) The Facility's 7.18 Medication & Treatment Orders - Renewal policy dated August 1, 2021, indicated medication and treatment orders must be renewed at least every 12 months or more frequently as required. The signed medication and treatment order renewals will be placed in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=E	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.	01890		

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01890	Continued From page 83 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to label time sensitive medications with a date when opened for two of two residents (R3, R7) 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) 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: R3 On October 5, 2021, at approximately 11:50 a.m. the 3rd floor locked medication cart was reviewed with unlicensed personnel (ULP)-N. R3's opened Basaglar 100 units/milliliter (insulin) pen lacked the date the pen had been opened, and when the pen would expire. On October 5, 2021, at approximately 11:50 a.m. ULP-N confirmed all insulin pens should be dated when opened. On October 6, 2021, at 3:23 p.m. nurse (RN)-L stated staff were to initial with date opened and expiration date on all insulin pens. The manufacturer's instructions for Basaglar dated July 2021, directed to discard the pen 28	01890		

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01890	Continued From page 84 days after it had been opened, even if it still had insulin left in it. R7 On October 5, 2021, at approximately 12:02 p.m. ULP-G was observed setting up scheduled insulin for R7. R7's medication administration record (MAR) indicated Novolog injectable flexpen, inject 4 units subcutaneous (applied under the skin) three times daily. R7's open Novolog insulin pen lacked the date the pen had been opened, and when the pen would expire. On October 5, 2021, at approximately 12:02 p.m. ULP-G confirmed all insulin pens should be dated when opened. On October 6, 2021, RN-L stated staff were to initial with date opened and expiration date on all insulin pens. The manufacturer's instructions for Novolog dated April 2015, directed to discard the pen 28 days after if has been opened, even if it still had insulin left in it. The facility lacked a policy regarding labeling time sensitive medications with a date when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01910	Continued From page 85	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of medications, including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R2) with record review. 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	01910		

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01910	Continued From page 86	01910		

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).

The findings include:

R2 was admitted on February 25, 2021. R2's diagnoses included, but was not limited to, Schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), major depressive disorder (mental health disorder having episodes of psychological depression), suicidal ideation (wanting to take your own life or thinking about suicide), generalized anxiety disorder (repeated episodes of sudden feelings of intense anxiety and fear), alcohol dependence, personal history of traumatic brain injury, chronic obstructive pulmonary disease (a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough).

R2's unsigned Service Plan Agreement, undated, identified he received services which included, but were not limited to, reminders for grooming and bathing, administration of medications, behavior management, and safety checks.

R2 was discharged on August 16, 2021. R2's record lacked evidence of a disposition of medications upon discharge.

On October 6, 2021, at approximately 9:40 a.m., registered nurse (RN)-Z stated the licensee did not complete a disposition of medications

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01910	Continued From page 87 because he went home and all medications were returned to him. The licensee's Medication Disposal policy dated August 1, 2021, identified, "upon disposition, the facility must document in the resident's record the disposition of the expired medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff (including a witness) and other individuals involved in the disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a	01940		

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01940	Continued From page 88 problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a signed service plan for the treatment or therapy services that will be provided to one of one resident (R7) for diabetic blood sugar monitoring with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R7 did not have a signed Service Plan to reflect the current treatment of blood sugar checks R7 received three times a day. R7's diagnoses included, but were not limited to, anemia (lack of red blood cells), anxiety, bilateral osteoarthritis of knees (form of arthritis), chronic	01940		

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01940	Continued From page 89 tremor (shaking movement in one or more parts of the body), edema (swelling caused by excess fluid trapped in tissue), and hypertension (high blood pressure). R7's record lacked current prescriber orders for blood sugar checks three times daily. R7's medication administration record (MAR) for October 1, 2021, through October 4, 2021, identified blood sugar checks were performed three times a day (before breakfast, lunch, and supper) and as needed per diabetic symptoms. The MAR indicated this task was performed and initialed off by staff. On October 5, 2021, at 12:02 p.m., unlicensed personnel (ULP)-G was observed taking R7's blood sugar by finger stick. ULP-G stated R7's blood sugars were checked three times a day which was listed on R7's MAR. On October 6, 2021, at 12:33 p.m., registered nurse (RN)-L confirmed R7 should be identified on the service plan. RN-L further verified R7 did not have a signed service plan identifying this treatment. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, identified for each treatment the licensee will prepare and include in the service plan a written statement of the treatment that will be provided to the resident. No further information is available. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		

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01970	Continued From page 90	01970		
01970 SS=D	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 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 ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R7) receiving treatments for records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R7's diagnosis included, but was not limited to, type 2 diabetes mellitus with hyperglycemia (high blood sugars). R7's comprehensive assessment dated October 6, 2021, identified R7 received blood glucose checks three times a day.	01970		

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01970	Continued From page 91 R7's record lacked a signed service plan agreement. R7's medical record lacked evidence of an up-to-date written prescriber order for the blood glucose check. On October 5, 2021, at 12:02 p.m., unlicensed personnel (ULP)-G performed a fingerstick blood glucose on R7. On October 6, 2021, at approximately 1:35 p.m., registered nurse (RN)-L and RN-K identified orders were not present in R7's record for blood glucose testing. The licensee's Medication and Treatment Orders policy dated August 1, 2021, identified the policy was to ensure a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber. And, to ensure ongoing evaluation of medications and treatments. 1) The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records; b. communicated to the resident or responsible party; c. educate resident or responsible party on all medication and treatment orders; and d. changes in orders are addressed in the resident's record and are communicated to the other staff; 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be	01970		

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01970	Continued From page 92 provided and the frequency, duration, and other information needed to carry out the order; and 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number,	02240		

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02240	Continued From page 93 website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents and information about how to make a complaint was provided to residents and a written acknowledgement received for six of six residents (R3, R5, R1, R8, R9, R4) with 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 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:	02240		

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02240	Continued From page 94 R3 began receiving assisted living services on August 1, 2021. R3's record noted a signed Minnesota Home Care Bill of Rights (May 16, 2021), signed and dated September 14, 2021 (45 days after the resident started receiving services). R5 began receiving assisted living services on August 1, 2021. R5's record noted a signed Minnesota Home Care Bill of Rights (May 16, 2021), signed and dated August 23, 2021 (23 days after the resident started receiving services). On October 6, 2021, at approximately 11:12 a.m., RN-Z stated the licensee did not have a signed contract which included the assisted living bill of rights for R3 and R5. R1 began receiving assisted living services on August 1, 2021. R1's record lacked evidence of the current Minnesota Home Care Bill of Rights (May 16, 2021). On October 5, 2021, unlicensed personnel (ULP)-G and ULP-S were observed to check, change, and reposition R1 in bed. R4's face sheet printed October 5, 2021, identified she was admitted on December 10, 2019. R4's service plan effective date October 5, 2021, indicated R4's received services which included bathing, dressing, transfers, urinary catheter (a tube that collects urine from the bladder and leads to a drainage bag) care, and medication administration. R4's service plan was signed on October 5, 2021, after it was requested by surveyor. R4's contract, which included the assisted living	02240		

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02240	Continued From page 95 bill of rights, was signed on October 5, 2021, after it was requested by the surveyor. R8's record lacked a service plan. On October 5, 2021, at approximately 9:35 a.m., ULP-G was observed administering medications to R8. R8's record lacked evidence of a signed contract, which included the assisted living bill of rights, had been received by R8. R9's record lacked a service plan. On October 5, 2021, at approximately 9:45 a.m., ULP-G was observed administering medications to R9. R9's record lacked evidence of a signed contract, which included the assisted living bill of rights, had been received by R9. On October 6, 2021, at 11:12 a.m., RN-Z stated the licensee did not have a signed contract which included the assisted living bill of rights for R8 and R9; there was no signed contract, which included the assisted living bill of rights for R4 prior to October 5, 2021. The licensee's 2.05 Bill of Rights policy dated August 1, 2021, noted the licensee would provide the resident or the resident's representative a written copy of the Assisted Living Bill of Rights (BOR) before the date that services are first initiated to the resident. No further information was provided. TIME PERIOD FOR CORRECTION:	02240		

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02240	Continued From page 96 Twenty-One (21) days	02240		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (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 provide the care and services according to acceptable health care, medical, or nursing standards for two of two residents (R6 and R1) with side rails with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6's diagnosis included, but was not limited to, malignant neoplasm (cancer that has spread) of liver and brain. R6's service plan, undated and unsigned, indicated R6 received services which included medication administration, housekeeping, assistance with bathing, dressing, grooming,	02310		

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ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

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02310	Continued From page 97 transferring, and toileting. On October 5, 2021, at approximately 12:15 p.m., R6 was observed eating lunch in his room. R6's bed was noted to have bilateral upper 1/4 side rails in the upright position. The bed was up against a wall, and from the foot of the bed, the right side rail bowed outward from bed at approximately 30 degrees. The rail was loose and wobbly when grabbed. R6 stated the side rail was hard to use stating, "I think its bent." R6's Side Rail Use Assessment Form dated May 25, 2021, identified the side rails were indicated to promote independence. The form further identified the positive and negative aspects of side rail use had been discussed with R6 and/or R6's family and parties were aware of the risks involved with side rail use. The assessment did not include a specific time to re-evaluate, but the form indicated 'duration of stay.' On October 5, 2021, at approximately 3:39 p.m., registered nurse (RN)-K and RN-L accompanied surveyor to R6's room. RN-K confirmed R6's bed rail was used to assist with positioning and mobility, and hospice had delivered this bed with rails to R6 in May 2021. RN-L confirmed R6's bed rail bowed outward at approximately 30 degrees and was loose and wobbly. Both RN-K and RN-L verified the side rail was a hazard to R6 in its current condition. RN-L attempted to tighten the side rail and identified it was not installed securely or in good operating condition. RN-L identified the side rail was attached incorrectly to the bed frame and backwards to the bed. Neither RN-K or RN-L could verify that the side rail in use was of a safe design and utilized consistent with the manufacturer's directions.	02310		

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	31417	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

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02310	Continued From page 98 On October 5, 2021, at approximately 3:39 p.m., RN-K verified R6's side rail had not been assessed for safety since May 2021, when the side rail was implemented by hospice. RN-K and RN-L stated side rail re-assessments were not a current practice, but they would expect staff to notify them of concerns. RN-K and RN-L also stated they were not aware of the Food and Drug Administration (FDA) guidance on Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006. R1's diagnoses included, but was noted limited to, deaf non-speaking, depression, hypertension (high blood pressure), dementia with behaviors, bipolar disorder, and type 2 diabetes with neuropathy. R1's service plan, undated and unsigned, indicated R1 received services which included medication administration, housekeeping, physical assistance with bathing, dressing, grooming, transferring, and toileting. R1's Side Rail Use Assessment Form dated September 20, 2021, identified the side rails were indicated to lower the chance of R1 rolling out of bed and to assist in repositioning. The form further identified the positive and negative aspects of side rail use had been discussed with R1 and/or R1's family and parties were aware of the risks involved with side rail use. The assessment did not include a specific time to re-evaluate, but the form indicated 'duration of stay.' On October 5, 2021, at approximately 9:31 a.m., R1 was observed lying in his bed. R1's bed was noted to have bilateral upper 1/4 side rails in the	02310		

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ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

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02310	Continued From page 99	02310		

upright position. The right side of the bed was up against a wall, and on the left side of the bed side rail bowed outwards from bed at approximately 30 degrees. The rail was loose and wobbly when grabbed.

On October 5, 2021, at approximately 3:39 p.m., RN-K and RN-L stated side rail re-assessments were not a current practice, but they would expect staff to notify them of concerns. RN-K and RN-L also stated they were not aware of the FDA guidance on Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006.

On October 5, 2021, at approximately 3:52 p.m., RN-K and RN-L accompanied surveyor to R1's room. RN-L confirmed R1's side rail was to assist R1 in sitting up. RN-L confirmed R1's bed rail bowed outward and was loose and wobbly. RN-L stated an assessment was recently completed on September 20, 2021, at which time she also readjusted the side rail. RN-L also stated at that time the side rail was not as bad as it was now. RN-L attempted to adjust the side railing and identified the left side rail was broken as she was unable to tighten it. RN-L removed the side rail from R1's bed.

The licensee's 6.28 Side Rails policy dated August 1, 2021, indicated staff would determine if the side rail is considered to be safe, regardless of who owns or is supplying the side rail. The policy noted staff will determine if the side rail is used consistent with manufacturer's directions, installed securely and maintained in good operating condition; be aware of "wobbly" side rails, and side rail design consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment.

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02310	Continued From page 100 The FDA, A Guide to Bed Safety, revised April 2010, included the following information: When bed rails are used, perform an on-going assessment of the patient's physical and mental status and closely monitor high-risk patients. The FDA also identified; Reassess the need for using bed rails on a frequent, regular basis. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02410 SS=E	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 where clearly inadvisable 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. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during	02410		

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02410	Continued From page 101 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 in double occupancy room for 10 of 46 residents (R6, R10, R12, R13, R14, R15, R16, R17, R18 and R19) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 October 4, 2021, at approximately 1:29 p.m. during the facility tour with registered nurse (RN)-Z, surveyors noted R18 and R19 to be in a shared room. The privacy curtain was hanging by a wire across the ceiling of the room. The curtain was sagging and the bottom of the curtain, approximately 2 feet, was laying on the floor of the room. On October 8, 2021, at 8:22 a.m., RN-L stated that some double occupancy rooms had a privacy curtain but some did not. During cares, such as dressing, grooming and incontinence care, it would not be possible to assure privacy for residents with a shared room due to lack of divider curtains. When the concern of divider	02410		

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02410	Continued From page 102 curtains had been brought to management's attention, she was told it was not necessary because this was not a nursing home. On October 8, 2021, at 10:00 a.m., RN-Z stated that not all of the double occupancy rooms had privacy curtains. Staff would not be able to maintain privacy during personal cares in those rooms. She stated the licensee was working on putting up privacy curtains. A list of the double occupancy rooms without privacy curtains was requested and provided. The list identified the following residents shared a double occupancy room without privacy curtains: -R12 and R13 -R14 and R15 -R6 and R10 -R16 and R17 -R18 and R19. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02410		
03000 SS=D	626.557 Subd. 3 Timing of report (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 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,	03000		

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03000	Continued From page 103 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 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:	03000		

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03000	Continued From page 104	03000		

Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R1) with record reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's diagnoses included, but were not limited to, deaf non-speaking, dementia with behavioral disturbance, depression, and bipolar disorder.

R1's Vulnerability Assessment/Abuse Prevention Plan dated June 9, 2021, indicated R1 was oriented to person and place, but has had a cognitive decline in the past year. R1 will displace behaviors towards staff including: holding onto their hands, attempts to bite staff, hitting, and kicking. The plan indicated R1 was susceptible to abuse due to ability to communicate related to diagnoses of deaf & non-speaking.

On August 28, 2021, at approximately 6:00 a.m., R1 was sitting in his wheelchair when unlicensed personnel (ULP)-A, ULP-B, and ULP-C entered the room to provide care. R1 bit ULP-A during cares, causing a break in the skin.

On August 28, 2021, at 6:15 a.m., the licensee's

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03000	Continued From page 105	03000		

Resident Incident Report identified R1 had bit ULP-A's hand during cares which required ULP-A to seek medication attention. The report did not identify the incident was reported as suspected maltreatment as the investigation indicated there was a previous history of R1 biting staff.

R1's progress note dated August 28, 2021, at 11:31 a.m. identified R1 bit a ULP-A and broke the skin. ULP-A went to the Emergency Department for evaluation. The progress note indicated R1's behaviors recently had increased and nothing further was mentioned.

The licensee's investigative report dated September 10, 2021, identified on August 28, 2021, ULP-A hit R1, restrained his hands, slapped him across the face, made lewd gestures, and called him names. The incident was reported on September 9, 2021, when ULP-C came forward and reported the incident to licensed practical nurse (LPN)-M and registered nurse (RN)-L.

R1's progress note dated September 14, 2021, at 4:49 p.m. late entry for September 13, 2021, identified R1's family member was notified of a suspected maltreatment report was submitted to MAARC.

On October 4, 2021, at 11:42 a.m., RN-Z stated the licensee followed the vulnerable adult reporting requirements if alleged abuse or neglect was suspected and reported to MAARC.

The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting Policy dated August 1, 2021, identified the facility educated staff about how to report suspected maltreatment internally and to the Minnesota

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03000	Continued From page 106 Adult Abuse Reporting Center (MAARC). Upon hire and annually all staff will be trained on identifying and reporting suspected maltreatment of vulnerable adults. Staff who suspect maltreatment of a resident or who has knowledge of abuse are to take immediate action to protect, or keep safe, the resident affected. Next, they are to contact the clinical nurse supervisor if medical attention needed and/or contact the assisted living director. The assisted living director or clinical nurse will confirm suspicion of maltreatment and contact the MAARC, such report must be made no later than 24 hours after first suspected. Staff reporting will not be retaliated against for making a good faith report of suspected maltreatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *10/04/21*
Time: 16:46:04
Report: 1028211023

Food and Beverage Establishment Inspection Report

Location:
Elmore Assisted Living
202 North St. East
Elmore, MN56027
Faribault County, 22

Establishment Info:
ID #: N000002
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Sunflower Communities
Troy Thompson
Phone #: 507-943-3333
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.

4-600 Cleaning Equipment and Utensils

4-602.11A ** Priority 1 **

MN Rule 4626.0845A Clean and sanitize food-contact surfaces of equipment and utensils: 1. before each use with a different type of raw animal food; 2. each time there is a change from working with raw foods to working with ready-to-eat foods; 3. between uses with raw fruits and vegetables and TCS foods; 4. before using or storing a food temperature measuring device; 5. at any time during the operation when contamination may have occurred.

Ensure that food thermometers are being cleaned and sanitized before storing them.

Comply By: 10/04/21

4-200 Equipment Design and Construction

4-201.11AMN

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

The domestic Whirlpool refrigerator in the pantry area must be replaced with a refrigerator that is certified by ANSI (NSF, UL EPH, ETL Sanitiation).

Comply By: 10/04/21

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

Damaged floor surfaces throughout the kitchen area must be replaced.

Comply By: 10/04/21

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

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

Ensure that mops are hung to dry after use. Discontinue leaves used mopheads in direct contact with the base of the mop sink.

Comply By: 10/04/21

Surface and Equipment Sanitizers

Chlorine: = 100ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Freezer
Temperature: 0 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: Cut melons
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: Whirlpool ambient
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Whirlpool ambient
Violation Issued: No

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

This Inspection was conducted in conjunction with HRD's Inspection of the Assisted Living Facility.

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 Dept. of Health inspection report number 1028211023 of 10/04/21.

Certified Food Protection Manager: Troy Thompson

Certification Number: FM73313 Expires: 10/04/23

Signed: _____
Troy Thompson
Executive Chef

Signed: _____
Ryan Miller
Environmental Health Spec. II
Mankato
ryan.miller@state.mn.us