DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

October 18, 2022

Administrator
Sophie's Manor Assisted Living
17500 Ranch Drive
Pine City, MN 55063

RE: Project Number(s) SL30576015

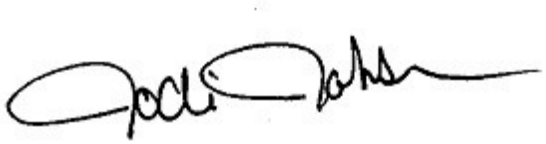
Dear Administrator:

On October 6, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the August 24, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

PMB

Electronically Delivered

September 8, 2022

Administrator
Sophie's Manor Assisted Living
17500 Ranch Drive
Pine City, MN 55063

RE: Project Number(s) SL30576015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 24, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statutes, Chapter 144A and/or Minn. Stat. § 626.5572 and/or Minn. Stat. 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. § 144A.474, Subd. 11(a), 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 § 144A.475 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

In accordance with Minn. Stat. § 144A.474, Subd. 11(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. Subd. 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. § 144A.474, Subd. 11(a)(6), 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. §§ 144A.43 to 144A.482, the following fines are assessed pursuant to this evaluation:

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144A.474, Subd. 8(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144A.474, Subd. 12, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order date.

A state licensing order under Minn. Stat. § 144A.44 Subd. 1(14), 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

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health

P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144A.474, subd. 11 (g), a home care 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. § 144A.475, subd 4 and subd. 7, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30576	A. BUILDING: _____ B. WING _____	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOPHIE'S MANOR ASSISTED LIVING	17500 RANCH DRIVE PINE CITY, MN 55063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30576015 On August 22, 2022, through August 24, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six (6) residents, all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on August 23, 2022, issued for SL#30576015, tag identification 2310. On August 23, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of G.	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.	

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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 licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 22, 2022, at 11:44 a.m., licensed assisted living director (LALD)-A identified herself as the LALD for the facility. LALD-A obtained an assisted living director license on July 7, 2021. On August 22, 2022, at approximately 1:30 p.m., the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD-A	0 110		

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0 110	Continued From page 2 held a current assisted living director license. The BELTSS website did not indicate LALD-A was listed as the Director of Record for the licensee. On August 22, 2022, at 1:36 p.m., LALD-A confirmed she was not listed as the Director of Record for licensee. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	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 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;	0 250		

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0 250	Continued From page 3 (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. (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 show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors.	0 250		

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0 250	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 22, 2022, at 11:38 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.	0 250		

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0 250	Continued From page 5 - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a	0 250		

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0 250	Continued From page 6 license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by owner (O)-F on May 20, 2021. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of June 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;	0 250		

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0 250	Continued From page 7 (2) handling complaints regarding staff or services provided by staff; (3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (4) infection control practices; (5) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (6) medication and treatment management; (7) delegation of tasks by registered nurses or licensed health professionals; (8) supervision of registered nurses and licensed health professionals; and (9) supervision of unlicensed personnel performing delegated tasks. On August 24, 2022, at approximately 2:00 p.m., LALD-A confirmed the licensee provided orientation, training, and competency evaluations of staff, handled complaints regarding staff or services provided by staff, conducted appropriate screening of tuberculosis, provided medication and treatment management services, followed infection control practices, and supervised ULP performing delegated tasks but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0110, 0470, 0480, 0485, 0510, 0550, 0660, 0680, 0780, 0800, 0810, 1420, 1440, 1470, 1490, 1620, 1640, 1650, 1890, 2310, and 2370 indicating the licensee's understanding of the	0 250		

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0 250	Continued From page 8 Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470		

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0 470	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the staffing schedule was posted as required. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a capacity of 11 residents and had a current census of 6 residents. On August 22, 2022, during the entrance conference at approximately 11:45 a.m., licensed assisted living director (LALD)-A verified the licensee had not developed a staffing plan to determine staffing levels needed to meet the needs of the residents. LALD-A stated, "we are down to six residents, we don't have anything in writing." On August 22, 2022, at approximately 12:00 p.m., LALD-A stated the usual staffing schedule for the facility was as follows: - registered nurse (RN) was on site "in house", "at	0 470		

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0 470	Continued From page 10 least" one day a week and on-call 24/7. - the day shift was staffed with one unlicensed personnel (ULP) from 7:00 a.m. to 3:00 p.m., and one ULP from 7:00 a.m. to 1:30 p.m. - the evening shift was staffed with one ULP from 3:00 p.m. to 9:30 p.m., and one ULP from 3:00 p.m. to 11:00 p.m. - the night shift was staff with one ULP from 11:00 p.m. to 7:00 a.m. On August 22, 2022, at 12:17 p.m., the surveyor toured the facility with LALD-A. The surveyor did not observe a posted staff schedule. On August 22, 2022, at 12:20 p.m., LALD-A confirmed there was no posted staff schedule, adding, "we can do that? I didn't know." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules,	0 480		

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0 480	Continued From page 11 chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 23, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) 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:	0 485		

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0 485	Continued From page 12 (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure weekly menus were made available to the residents. This had the potential to affect all six (6) residents. 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: During the entrance conference on August 22, 2022, at approximately 11:45 a.m., licensed assisted living director (LALD)-A stated the licensee provided three meals daily to include fresh fruit and vegetables and snacks were offered. During a tour of the licensed facility on August 22, 2022, at 12:17 p.m., the surveyor observed a	0 485		

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0 485	Continued From page 13 single-day menu written on a white board attached to the refrigerator. On August 22, 2022, at 12:20 p.m., LALD-A stated they used a six-week rotation of menus which were kept in the kitchen, pointing to a locked cabinet. LALD-A confirmed weekly menus were not posted or provided to the residents No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: 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 had the potential to affect all residents.	0 510		

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0 510	Continued From page 14 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The Minnesota Department of Health (MDH) guidance titled, "COVID-19 [personal protective equipment (PPE)] and Source Control Grids - for congregate care settings, by community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with clients without suspected or confirmed SARS-CoV-2 infection. On August 23, 2022, at 12:20 p.m., during a tour of the facility the surveyor observed two unlicensed personnel (ULP) assisting residents in the open dining/commons area. The ULP's were standing closely to residents of the facility conversing with them. ULP-B was in direct contact with the R2 assisting with the noon meal. ULP- B was wearing a surgical grade mask, but no eye protection. On August 23, 2022, at 12:30 p.m., RN-C verified staff were not currently wearing eye protection. RN-C stated she "thought" it [COVID-19 guidelines] changed last week, "it [regulations] changes a lot." The surveyor checked the	0 510		

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0 510	Continued From page 15 Minnesota transmission rate on the CDC website in RN-C's presence, the transmission rate was high. RN-C acknowledged she knew how and where to check the current transmission levels, adding, "I get it emailed to me at my other job." RN-C accepted the offer of the surveyor to send the CDC website to the licensee's email address. Licensed assisted living director (LALD)-A acknowledged receipt of the email. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all	0 550		

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0 550	Continued From page 16 current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 22, 2022, at 12:17 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. The main entrance and/or common areas lacked the required posting for the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. On August 22, 2022, at 1:34 p.m., LALD-A verified the required grievance procedure content had not been posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 660 SS=D	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	0 660		

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0 660	Continued From page 17 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 maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptom screenings was completed and documented for one of two employees (registered nurse (RN)-C) with employee 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: The licensee's TB risk assessment dated March 29, 2022, indicated the facility's risk level as low.	0 660		

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0 660	Continued From page 18 RN-C's employee records lacked documentation of a completed health history and symptom screening. RN-C was hired on March 4, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's employees under the assisted living license. On August 23, 2022, at approximately 10:15 a.m., licensed assisted living director (LALD)-A verified RN-C had not completed a TB history and symptom screening. RN-C briefly looked through her employee file and pointed to a Quantiferon TB Gold Plus (TB blood test) collected on May 18, 2022, and commented, "that is it." The licensee's Facility TB Risk Assessment Instructions and Worksheet for Health Care Setting Licensed by Minnesota Department of Health (MDH) updated June 2021, confirmed baseline TB screening was required at the time of hire for all health care personnel. 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	0 680		

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0 680	Continued From page 19 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and post a written emergency preparedness plan with all the required content. This had the potential to affect all residents, staff, and visitors of 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 22,	0 680		

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0 680	Continued From page 20 2022, at 12:08 p.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided to and later reviewed by the surveyor. On August 22, 2022, at 12:15 p.m., a facility tour was conducted with licensed assisted living director (LALD)-A. There was no observed signage posted or information regarding the licensee's EPP in the common areas of the facility. The licensee's plan included a hazard vulnerability risk assessment and policies for water storage, winter storms, electrical failure, severe weather, heat and humanity, fire, bomb and threats and natural disasters. The licensee's EPP lacked the following required content: - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a missing resident plan that was reviewed quarterly; - arrangements/contracts to re-establish utility services; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency; - evacuation plan; - transportation plans; - identification of evacuation location(s); - alternate sources of energy, to maintain temperatures to protect resident health/safety;	0 680		

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0 680	Continued From page 21 - shelter in place; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; - the facilities role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities; and -plan was not reviewed annually. On August 22, 2022, at approximately 1:55 p.m., licensed assisted living director (LALD)-A confirmed they had not fully developed and implemented the facility's emergency preparedness plan/program as required. The licensee's Disaster Planning and Emergency Preparedness Plan policy revised October 5, 2021, indicated the facility would have in place a written plan of action to facilitate the management of resident cares and services in response to a natural disaster or other emergencies that may disrupt their ability to provide care and/or services. Disaster plans for events that are considered to have a high probability with high risk would be developed. In addition, when service was provided the facility would coordinate emergency planning and would have a plan for both sheltering in place and evacuations. Also, the plans should take into account the potential inability of staff to provide services to residents at time of emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 780	Continued From page 22	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain smoke alarms that are interconnected throughout the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 780		

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0 780	Continued From page 23 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On August 22, 2022, between 12:00 p.m. and 1:30 p.m. with the licensed administrator (LALD)-A, during the facility tour, survey staff observed the following: 1. The smoke alarm in the stock room was missing. 2. The smoke alarms in the second floor hallway, room 23, rooms 12 and 13 are outdated. 3. The smoke alarm in room 11 has been removed due to a remodel of the room. 4. The smoke alarm in room 12 could not be heard in the room when tested. LALD-A verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 22, 2022, between 12:00 p.m. and 1:30 p.m., survey staff toured the licensed administrator (LALD)-A. During the facility tour, survey staff observed the following: 1. There is no grab bars installed in the second floor bathroom. 2. The suction cup grab bar in the shower needs to be replaced to a secured grab bar on the main level. 3. Light fixture fixture was hanging in the stock room. LALD-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 810	Continued From page 25	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 810		

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0 810	Continued From page 26 licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, 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). On August 22, 2022, between 12:00 p.m. and 1:30 p.m., the licensed administrator (LALD)-A failed to provide documents for review. 1. The licensee failed to provide employee training logs for fire safety and evacuation. 2. The licensee failed to provide the required employee training frequency. 3. The licensee failed to provide documentation of resident evacuation training. The LALD-A verbally confirmed survey staff observations during the facility tour. No additional information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services	01420		

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01420	Continued From page 27 (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks 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 registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP)-B who used a door alarm for 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 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: ULP-B was hired November 2, 2015, under the comprehensive home care license and began providing assisted living services on August 1,	01420		

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01420	Continued From page 28 2021. On August 23, 2022, at 7:18 a.m., the surveyor observed ULP-B reach to the top of R2's door and turn off a door alarm [an alarm attached to the door frame and the side of the door that when contact was lost sounds an alarm: each time the door was opened]. ULP-B's record lacked documentation to indicate ULP-B had received training and demonstrated competency for door alarm. On August 24, 2022, at 8:36 a.m., licensed assisted living director (LALD)-A confirmed none of the staff working at the facility had been trained and demonstrated competency for alarms. The licensee's Delegation of Nursing Services policy revised October 1, 2021, indicated prior to the delegation the registered nurse (RN) would train ULP's on the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420		
01440 SS=F	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	01440		

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01440	Continued From page 29 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 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 direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for two of two unlicensed personnel (ULP-B, ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01440		

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01440	Continued From page 30 ULP-B ULP-B was hired November 2, 2015, under the comprehensive home care license and continued to provide direct care services to residents of the facility under the assisted living license beginning August 1, 2021. On August 23, 2022, at 7:50 a.m., the surveyor observed ULP-B remove R2's morning oral medications from a medication cart and administer medication to R2. ULP-B's employee record lacked documentation of a registered nurse (RN) supervising ULP-B performing a delegated task within 30 days of beginning work with the licensee. ULP-D ULP-D was hired on July 8, 2021, to provide direct care services to residents of the facility. ULP-D's employee record lacked documentation of a registered nurse (RN) supervising ULP-D performing a delegated task within 30 days of beginning work with the licensee. On August 24, 2022, at 8:36 a.m., licensed assisted living director (LALD)-A confirmed the RN had not completed a 30-day supervision of delegated tasks for ULP-B or ULP-D. LALD-A verified all ULPs had training of delegated tasks completed on hire and again at 90 days, not at 30 days. The licensee's undated Supervision of ULP indicated ULP would have an evaluation given by an RN within 30 days after the individual began working and had taken the competency test for the home care provider and thereafter as needed based on performance.	01440		

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01440	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=D	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	01470		

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01470	Continued From page 32 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content was completed for one of two employees, registered nurse (RN)-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	01470		

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01470	Continued From page 33 only occasionally). The findings include: RN-C was hired on March 4, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. RN-C's employee records lacked the following required orientation content: - an overview of the 144G statutes; - consumer 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 August 24, 2022, at approximately 9:35 a.m., licensed assisted living director, (LALD)-A confirmed RN-C had not completed the above noted orientation as required. The licensee's Orientation Training for Assisted Living Staff revised October 1, 2021, indicated all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation must contain the following topics: - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

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01470	Continued From page 34 - the assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights; - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - 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; - a review of the types of assisted living services the employee will be proving and the facility's category of licensure; and - in addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by:	01490		

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01490	Continued From page 35 Based on interview and record review, the licensee failed to ensure staff received dementia training as required for one of two employees, registered nurse (RN)-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 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: RN-C was hired on March 4, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. RN-C's employee record lacked documentation of completion of eight hours of initial training within 120 working hours of first day of employment. RN-Cs employee file contained a transcript from an on-line training course; dates of completion ranged from March 8, 2022, through March 11, 2022. RN-C's transcript failed to include: - an explanation of Alzheimer's diseases and other dementias; and - 4.5 hours of dementia training. Transcript included 3.5 hours of dementia training. RN-Cs employee record included an outline of regulatory requirements, including dementia training from select dementia courses from the on-line learning library to reach 8 credits, and subjects required. The deadline written was within	01490		

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01490	Continued From page 36 120 working hours. There was a pen mark by the deadline and the form was authenticated by licensed assisted living director (LALD)-A and included her title, however there was not a date on the form. On August 23, 2022, at 10:13 a.m., LALD-A confirmed RN-C had not completed the required dementia training within the specified time frames. The licensee's Dementia Training policy revised October 1, 2021, indicated all direct-care staff would have eight hours of initial training on the topics: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620		

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01620	Continued From page 37 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 observation, interview, and record review the licensee failed to ensure the registered nurse (RN) completed reassessment with change of condition in evacuation status for one of one resident (R2) 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). R2's diagnoses included Alzheimer's disease with behavioral disturbance, amnesia, hallucinations, delirium due to another medication, and hypertension (HTN). R2's Service Plan dated August 19, 2022,	01620		

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01620	Continued From page 38 indicated R2 received services which included medications (management, set-up for planned and unplanned leave of absence, administration, blood pressure monitoring prior to medication) weekly vital signs (Wednesday) as needed (PRN), bathing assistance (Monday and Thursday), hygiene/grooming assistance (combing hair, reading glasses, oral cares, twice a day and PRN, shaving assist), dressing (set up and PRN), toileting (stand by assist (SBA), laundry, housekeeping, food preparation, behavior monitoring and interventions (wanders, monitor for anxiety/depression, monitor sleep cycle, re-direction, room alarm on at hour of sleep (HS), monitor drooling and leaning to one side, antipsychotic monitoring, staff to assist with chair lift), exercise, mobility ambulation (daily stretching and exercise, independent to SBA with 2 wheeled walker due to occasional unsteady gait. SBA during HS hours due to unsteady gait. May need to utilize wheelchair for long distance ambulation), activities, environment, and communication assistance: able to communicate wants and needs, staff to anticipate wants and needs. R2's record included a Resident Evacuation Assessment dated August 4, 2021, authenticated by a registered nurse (RN) which included: Impaired Mobility: - self-starting; yes - slow: no - needs limited assistance: no - needs full assistance or very slow: no - very slow: no Impaired Consciousness - no significant risk: yes - partially impaired; no	01620		

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	30576	A. BUILDING: _____ B. WING _____	08/24/2022

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SOPHIE'S MANOR ASSISTED LIVING	17500 RANCH DRIVE PINE CITY, MN 55063

(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 39 - totally impaired: no Need for Extra Staff - needs only one staff: yes - needs limited assistance from two staff: no - needs full assistance from two staff: no Response to Instructions (Staff Directed Evacuation) - follows directions: no - requires supervision: yes - requires considerable attention or may not respond: no Waking Response to Alarm - response probable: no - response not probable: yes Response to Fire Drills (Self-Directed Evacuation) - initiates and completes evacuation promptly: yes - chooses and completes back-up strategy: no Stays at Designated Location in a Safe Area - yes score is given if the resident has demonstrated that he will stay at a designated safe location during fire drills: yes. Remarks handwritten on the bottom of the form notes:" [name] stated he would get out if there was an alarm." On August 23, 2022, at 7:18 a.m., the surveyor observed unlicensed staff (ULP)-B reach to the top of R2's door and turn off a door alarm [an alarm attached to the door frame and the side of the door that when contact was lost sounds an alarm: each time the door was opened]. On August 23, 2022, at 7:18 a.m., directly after above mentioned observation of ULP-B shutting	01620		

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01620	Continued From page 40 off the alarm on R2's door, ULP-B stated about R2's door alarm, "when he [R2] opens the door it so goes off so we know he is up, he gets up a lot, chance of falling." On August 23, 2022, at 7:39 a.m., the surveyor observed ULP-B assist R2 into a chair lift at the top of a staircase, fasten a belt across his body and place R2's feet on the foot pad on the platform under the seat and lower him to the ground level. On August 24, 2022, at approximately 9:00 a.m., RN-C and licensed assisted living director (LALD)-A verified all residents are assisted with the chair lift, no resident uses without staff assist. On August 24, 2022, at approximately 10:50 a.m., RN-C confirmed R2 was not longer able to ambulate independently as he did at the time of admission and the assessment did not meet R2's current needs. The licensee's Assessments - Schedules policy revised October 7, 2021, indicated an Evacuation Assessment would be completed at admission and annually by an RN, face to face. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640		

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01640	Continued From page 41 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 service plans were implemented for one of three residents (R2) with records reviewed. In addition, the licensee failed to ensure services plans were revised to reflect the current services provided for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a client'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	01640		

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01640	Continued From page 42 found to be pervasive). The findings include: SERVICE PLAN IMPLEMENTATION R2's record lacked documentation the service plan was implemented as written. R2's diagnoses included Alzheimer's disease with behavioral disturbance, amnesia, hallucinations, delirium due to another medication, and hypertension (HTN). R2's Service Plan dated August 19, 2022, indicated R2 received services which included medications (management, set-up for planned and unplanned leave of absence, administration, blood pressure monitoring prior to medication) weekly vital signs (Wednesday) as needed (PRN), bathing assistance (Monday and Thursday), hygiene/grooming assistance (combing hair, reading glasses, oral cares, twice a day and PRN, shaving assist), dressing (set up and PRN), toileting (stand by assist (SBA), laundry, housekeeping, food preparation, behavior monitoring and interventions (wanders, monitor for anxiety/depression, monitor sleep cycle, re-direction, room alarm on at hour of sleep (HS), monitor drooling and leaning to one side, antipsychotic monitoring, staff to assist with chair lift), exercise, mobility ambulation (daily stretching and exercise, independent to SBA with 2 wheeled walker due to occasional unsteady gait. SBA during HS hours due to unsteady gait. May need to utilize wheelchair for long distance ambulation), activities, environment, and communication assistance: able to communicate wants and needs, staff to anticipate wants and needs.	01640		

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01640	Continued From page 43 On August 23, 2022, at 7:18 a.m., the surveyor observed unlicensed staff (ULP)-B reach to the top of R2's door and turn off a door alarm [an alarm attached to the door frame and the side of the door that when contact was lost sounds an alarm: each time the door was opened]. On August 23, 2022, at 7:39 a.m., the surveyor observed ULP-B assist R2 into a chair lift at the top of a staircase, fasten a belt across his body and place R2's feet on the foot pad on the platform under the seat and lower him to the ground level. R2's Activities of Daily Living (ADL) Log dated August 1, 2022, through August 23, 2022, failed to include door alarm and assist with chair lift to verify the service plan was being followed as written. On August 23, 2022, at 10:13 a.m., registered nurse (RN)-C confirmed there was no documentation to verify the service plan was being implemented as written, for door alarm or chair lift. SERVICE PLAN REVISION R4's service plan did not reflect the current services being provided. R4's diagnoses included dementia, depression, general anxiety disorder and hot flashes. R4's Service Plan dated May 23, 2022, indicated R4 received services which included medications (management, set-up for planned and unplanned leave of absence, administration) weekly vital signs (Wednesday) as needed (PRN), bathing assistance (Tuesday and twice daily cares),	01640		

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01640	Continued From page 44	01640		

hygiene/grooming assistance (combing hair, oral cares, twice a day and PRN), dressing (twice a day and PRN), toileting (every 2 hours), laundry, housekeeping, food preparation, behavior monitoring and interventions (24 hour supervision, monitoring for anxiety/depression, monitor hours of sleep, monitor pacing, monitor behaviors, door alarm to alert staff when awake and wandering on Night (NOC's), ambulation (daily stretching and exercise, use of lift chair to ascend and descend by staff, encourage activities), exercise, mobility, activities, environment, and communication assistance: staff to anticipate wants and needs.

On August 23, 2022, at 6:42 a.m., the surveyor observed R4 wandering the main floor of the facility.

On August 23, 2022, at approximately 10:15 a.m., RN-C confirmed R4's service plan had was not correct. RN-C verified R4 does not use lift chair to ascend or descend; R4's room is on the main floor of the facility.

On August 24, 2022, at approximately 11:45 a.m., RN-C stated R4's door alarm was no longer in use.

The licensee's Service Plans policy revised October 7, 2021, indicated facility staff would implement and provide all services required by the current service plan. In addition, the service plan must be revised, if needed, based on the results of required resident monitoring and/or reassessments.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one

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01640	Continued From page 45 (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for one of one	01650		

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01650	Continued From page 46	01650		

resident (R2) with records reviewed. This had the potential to affect all six (6) residents who received services at the facility.

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 the potential to affect a large portion or all the residents).

The findings include:

R2's diagnoses included Alzheimer's disease with behavioral disturbance, amnesia, hallucinations, delirium due to another medication, and hypertension (HTN).

On August 23, 2022, at 7:39 a.m., the surveyor observed unlicensed staff (ULP)-B assist R2 into a chair lift [motorized chair that travels along a rail that is securely bolted to the steps] at the top of a staircase, fasten a belt across R2's body and place R2's feet on the foot pad on the platform under the seat and lower him to the ground level.

R2's Service Plan dated August 19, 2022, indicated R2 received services which included medications (management, set-up for planned and unplanned leave of absence, administration, blood pressure monitoring prior to medication) weekly vital signs (Wednesday) as needed (PRN), bathing assistance (Monday and Thursday), hygiene/grooming assistance (combing hair, reading glasses, oral cares, twice a day and PRN, shaving assist), dressing (set up and PRN), toileting (stand by assist (SBA), laundry, housekeeping, food preparation,

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01650	Continued From page 47 behavior monitoring and interventions (wanders, monitor for anxiety/depression, monitor sleep cycle, re-direction, room alarm on at hour of sleep (HS), monitor drooling and leaning to one side, antipsychotic monitoring, staff to assist with chair lift), exercise, mobility ambulation (daily stretching and exercise, independent to SBA with 2 wheeled walker due to occasional unsteady gait. SBA during HS hours due to unsteady gait. May need to utilize wheelchair for long distance ambulation), activities, environment, and communication assistance: able to communicate wants and needs, staff to anticipate wants and needs. R2's Service Plan lacked the following required content: - the methods of monitoring assessment of the resident; - the methods of monitoring staff providing services; and - the frequency of medication administration services. On August 23, 2022, at 12:05 p.m., licensed assisted living director (LALD)-A confirmed R2's service plan was incomplete and did not include the above noted content. LALD-A verified all the service plans would be missing the above-mentioned required content. The licensee's Service Plans policy revised October 7, 2021, indicated service plans would include a method of monitoring reviews or assessments of the resident and the frequency of each service, according to the resident's current review or assessment and resident preferences No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01650		

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01650	Continued From page 48 (21) days	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications for two of six residents (R1, R3). 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: On August 22, 2022, at 12:44 p.m., the surveyor and registered nurse (RN)-C reviewed the medication cart located along a wall in the open kitchen/dining area. The medication cart included: -R1's opened CarraKlenZ dermal wound cleaner [gentle, emulsifying, safe, and effective solution for removing organic material, debris, and dead tissue from wounds], had an expiration date of	01890		

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01890	Continued From page 49 September 2019. -R3's unopened glucose tablets [product containing fast-acting carbohydrates to quickly raise blood sugar] had expired on March 2, 2021. On August 22, 2022, directly following the medication cart review RN-C verified the above medications were expired and should have been removed from the medication cart. The licensee's Storage policy revised October 5, 2021, indicated medication would be stored consistent with manufacturer's recommendation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=G	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 care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with side rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	02310		

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02310	Continued From page 50	02310		

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).

This resulted in an immediate correction order on August 23, 2022, at 3:10 p.m.

The findings include:

R1's diagnoses included, vascular dementia with behavior disturbance, weakness of both lower extremities, high blood pressure, urinary incontinence, chronic kidney disease, prostatic hypertrophy [prostate enlargement], and traumatic amputation of finger right hand.

On August 23, 2022, at 6:59 a.m., the surveyor observed R1 sitting in a recliner in a commons area. Unlicensed personnel (ULP)-D assisted R1 to a standing position with aid of a transfer belt and a four wheeled walker.

On August 23, 2022, at 8:24 a.m., the surveyor interviewed R1 regarding his care, treatment and needs. R1 gave permission for the surveyor to look in his room. R1's bed was a hospital bed with a half side rail in the lowered position. The side rail was secured to the hospital bed.

On August 23, 2022, at 2:56 p.m., ULP-B stated R1 used the side rails to assist getting in and out of bed.

R1's service plan dated August 9, 2022, indicated the resident received the following services: medication management, assist with diabetic shoes with ankle foot orthosis (AFO's) [used to improve walking patterns by reducing, preventing

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or limiting movement of the lower leg and foot by supporting weak muscles] compression socks, daily blood pressure monitoring, vital sign monitoring weekly, assistance with bathing, hygiene/grooming, dressing assistance, toileting, laundry, housekeeping, food preparation, behavior monitoring, ambulation, exercise, mobility, activities, environment, and communication.

R1's Standard Assessment dated July 26, 2022, indicated R1 requires with transfer to/from bed, to/from chair, and turning and position in in bed/chair.

R1's Side Rail Utilization Assessment dated May 23, 2022, included the purpose of the right-side rail to reposition in bed and get out of bed as needed. The assessment also included a statement that the resident and the resident's representative had been provided information on the risks and benefits of side rails. The assessment did not include actual measurements of the entrapment zones.

On August 23, 2022, at 3:04 p m., RN-C measured R1's side rail with surveyor present. The bed rail measured 9" inches tall by 2.1 inches wide and 17 inches tall by 2 inches wide, which was in compliance with FDA guidelines for side rails.

The licensee's Siderails policy revised October 7, 2021, refers to the 2006, Food and Drug Administration recommendations for reducing entrapments, "This means side rail zones 1, 2, and 3 must not exceed 4.75 inches."

The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations

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	30576	A. BUILDING: _____ B. WING _____	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOPHIE'S MANOR ASSISTED LIVING	17500 RANCH DRIVE PINE CITY, MN 55063

(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
02310	Continued From page 52 indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches. 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, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by surveyor's on-site observations and review by evaluation supervisor on August 23, 2022, however, non-compliance remains at a scope and severity of level three, isolated (G). TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02370 SS=F	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced	02370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30576	A. BUILDING: _____ B. WING _____	08/24/2022

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02370	Continued From page 53 by: Based on observation, interview and record review, the licensee failed to ensure residents have the right to come and go from the facility as they choose. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license issued on August 1, 2022, with an expiration date of June 30, 2023. On August 22, 2022, at 12:15 p.m., the surveyor toured facility with licensed assisted living director (LALD)-A. The facility consisted of three resident occupied rooms on ground level and three occupied resident rooms on the upper level. ENTRYWAY The main entrance door of the facility led through a short hallway which had a small table on it with information about admission to the facility: Criteria to Reside at [name of facility] - must be 55 years and older; - can have a diagnosis of dementia or a related diagnosis; - be medically stable but require 24 hour intervention due to cognitive impairment; - be safe to themselves and others; - have family or Responsible Party who is able to	02370		

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	30576	A. BUILDING: _____ B. WING _____	08/24/2022

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02370	Continued From page 54	02370		

participate and cooperate with personal needs and plan of care of Resident;
- have personal and medical needs that are manageable with staff intervention (bathing, dressing, grooming, incontinence, nutrition);
- have the ability to function safely with the services of 24-hour on-site home care staff and within limited RN monitoring or intervention;
- have the ability, with or without assistance, to pay all amounts due to Management and any other Home Care Agency providing services.

ENTRANCE TO LIVING SPACE
The entry led to a wooden door with an alarm on the top of the door used to alert staff the door had been opened. The doorknob on the inside of the wooden door had a plastic cover over it/child lock [designed to fit over most standard doorknobs, acting as a deterrent to open the door.] The plastic cover needed to be squeezed or "pinched" to open. Manufacturer's instructions included "should seem quite inaccessible for children". Above the plastic covered doorknob in the center of the door was an "EXIT" sign.

Immediately to the right of the exit door was a white door that led outside to a front covered porch. On the top of the white door was a bolt type of latch [sliding a rod into a securing bolt to hold door in position] in the locked position. There was also an alarm on the top of the door which alerted staff the door had been opened.

Two other doors on the main level had the plastic covers over them. One was on a door marked pantry and the other was on the basement door with a sign indicating "Employee breakroom, stock room, craft room, employee bathroom, EXIT (in red) seeking door."

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	30576	A. BUILDING: _____ B. WING _____	08/24/2022

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SOPHIE'S MANOR ASSISTED LIVING	17500 RANCH DRIVE PINE CITY, MN 55063

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02370	Continued From page 55 UPPER LEVEL The staircase leading to the upper level included a chairlift [motorized chair that travels along a rail that is securely bolted to the steps]. At the top of the stairway there was a piece of wood (half door like) on hinges which was secured in a closed position with a gate type of latch [gravity latch, the force of the swing allows the latch arm to push past the strike plate and fall into the catch, securing the gate] located on stair side of the panel confining residents on the upper level. If/when one wanted to exit the upper level, a person or resident needed reach down to the stair side of the half door and unfasten the latch to release the closure. R2 R2's diagnoses included Alzheimer's disease with behavioral disturbance, amnesia, hallucinations, delirium due to another medication, and hypertension (HTN). R2's Service Plan dated August 19, 2022, indicated R2 received services which included medications (management, set-up for planned and unplanned leave of absence, administration, blood pressure monitoring prior to medication) weekly vital signs (Wednesday) as needed (PRN), bathing assistance (Monday and Thursday), hygiene/grooming assistance (combing hair, reading glasses, oral cares, twice a day and PRN, shaving assist), dressing (set up and PRN), toileting (stand by assist (SBA), laundry, housekeeping, food preparation, behavior monitoring and interventions (wanders, monitor for anxiety/depression, monitor sleep cycle, re-direction, room alarm on at hour of sleep (HS), monitor drooling and leaning to one side, antipsychotic monitoring, staff to assist with chair lift), exercise, mobility ambulation (daily stretching	02370		

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02370	Continued From page 56	02370		

and exercise, independent to SBA with 2 wheeled walker due to occasional unsteady gait. SBA during HS hours due to unsteady gait. May need to utilize wheelchair for long distance ambulation), activities, environment, and communication assistance: able to communicate wants and needs, staff to anticipate wants and needs.

On August 23, 2022, at 7:39 a.m., the surveyor observed unlicensed staff (ULP)-B reach to the far side of the half door from where she was positioned to unlatch the gate fastener and assist R2 into chairlift at the top of the staircase, fasten a belt across R2's body and place R2's feet on the foot pad on the platform under the seat and lower R2 to the ground level.

On August 23, 2022, directly following the above observation, ULP-B stated the "gate" was locked and that R2 is not able to get it [gate opened] himself.

On August 22, 2022, at approximately 1:15 p.m., LALD-A stated the state fire marshal told her it [the closed and secured wooden half door/gate at the top of the stairs] would need to be removed and LALD-A stated she would remove it after the survey concluded.

R4
R4's diagnoses included dementia, depression, general anxiety disorder and hot flashes.

R4's Service Plan dated May 23, 2022, indicated R4 received services which included medications (management, set-up for planned and unplanned leave of absence, administration) weekly vital signs (Wednesday) as needed (PRN), bathing assistance (Tuesday and twice daily cares), hygiene/grooming assistance (combing hair, oral

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02370	Continued From page 57	02370		

cares, twice a day and PRN), dressing (twice a day and PRN), toileting (every 2 hours), laundry, housekeeping, food preparation, behavior monitoring and interventions (24 hour supervision, monitoring for anxiety/depression, monitor hours of sleep, monitor pacing, monitor behaviors, door alarm to alert staff when awake and wandering on Night (NOC's), ambulation (daily stretching and exercise, use of lift chair to ascend and descent by staff, encourage activities), exercise, mobility, activities, environment, and communication assistance: staff to anticipate wants and needs.

On August 23, 2022, at 6:42 a.m., the surveyor observed R4 wandering the main floor of the facility and was redirected by ULP-B.

On August 23, 2022, at approximately 9:30 a.m., the surveyor asked LALD-A, "would it be a locked facility if they can't open the door [regarding the plastic door locks]?" LALD-A replied, "yes, I assume. I can take them off."

On August 23, 2022, at approximately 10:40 a.m., LALD-A stated it [door latch on the white door next to the porch exit] was not to be locked. The surveyor informed LALD-A the door was latched/locked at "this" time.

On August 23, 2022, at approximately 2:40 p.m., the surveyor observed the top latch on the white door was engaged/locked.

On August 24, 2022, at 10:45 a.m., ULP-B and ULP-E both indicated everything is locked, pointing to doors and counted 1,2,3,4, adding, "and all doors have alarms" when asked about elopements. ULP-B went over to the door and locked it, stating "it should be locked" after the

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02370	Continued From page 58 surveyor asked about the white front door. On August 25, 2022, at approximately 2:05 p.m., LALD-A had removed the plastic doorknob covering/child lock. The Minnesota Bill of Rights for Assisted Living Residents dated May 16, 2021, indicates that residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other laws and consistent with a resident's service plan. In addition, residents have the right to be treated with courtesy and respect. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02370		

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *08/23/22*
Time: 11:30:00
Report: 1016221133

Food and Beverage Establishment Inspection Report

Location:
Sophie'S Manor Assisted Living
17500 Ranch Drive
Pine City, MN55063
Pine County, 58

Establishment Info:
ID #: 0037745
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3206292064
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13A ** Priority 2 **

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

A TEMPERATURE MEASURING DEVICE WAS NOT AVAILABLE FOR MEASURING DISH WASHER TEMPERATURE. OBTAIN A TEMPERATRE MEASURING DEVICE AND NOTIFY INSPECTOR.

Comply By: 08/26/22

6-300 Physical Facility Numbers and Capacities

6-301.11 ** Priority 2 **

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

KITCHEN HAND SINK DID NOT HAVE HAND SOAP AVAILABLE. STAFF REPLACED HAND SOAP DURING INSPECTION.

Corrected on Site

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

A CFPM WAS NOT EMPLOYED. HAVE STAFF TAKE A FOOD SAFETY CLASS AND REGISTER CERTIFICATE WITH MDH. CFPM INFORMATION EMAILED TO STAFF.

Comply By: 09/30/22

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

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

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

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

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

COMMENTS:

DISCUSSED SAME DAY FOOD PREP AND SUSCEPTIBLE POPULATION LIMITATIONS

SUSCEPTIBLE POPULATION FACT SHEET EMAILED.

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1016221133 of 08/23/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Ashley Wasson

Signed:_____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us