Electronically Delivered

August 2, 2024

Licensee
ScandiHaven of Cura
1710 McKinney Avenue
Benson, MN 56215

RE: Project Number(s) SL33727015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 10, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33727	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDI HAVEN VILLAGE	1710 MCKINNEY AVENUE BENSON, MN 56215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33727015 On July 8, 2024, through, July 10, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 77 resident(s); 53 receiving services under the provider's Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of one employee (unlicensed personnel (ULP)-H). 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).	0 650		

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0 650	Continued From page 2 The findings include: ULP-H was hired on January 1, 2023, to provide direct care services to the licensee's residents. On July 9, 2024, at 7:39 a.m. ULP-H was observed to administer medications to R8. ULP-H's record lacked evidence of the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - documentation of annual performance review that identify areas of improvement needed and training needs. On July 10, 2024, at 10:54 a.m. registered nurse (RN)-D stated the above content was missing from ULP-H's employee record and may have been missed. The licensee's Employee File-Employee Records policy, dated May 2023, indicated employee records for each record would include: -current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any; and -documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 3 (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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had	0 810		

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0 810	Continued From page 4 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). The findings include: On July 09, 2024, at 12:17 p.m., licensed assistant living director in residency (LALDIR)-A and maintenance supervisor (MS)-K provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee or resident actions to be taken in the event of a fire or similar emergency. The facility plan was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency as well as complete procedures for residents' movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The current plan was general and referenced the RACE (rescue, alarm, confine, extinguish and evacuate) acronym. During interview, LALDIR-A and MS-K verified that the fire safety and evacuation plan for the facility lacked these provisions.	0 810		

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0 810	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications included the open date and/or expiration date for the three residents receiving insulin administration (R2, R4, R6) and one resident observed with time sensitive eye drops (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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 July 9, 2024, at 7:18 a.m. unlicensed personnel (ULP)-E opened R2's locked	01890		

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01890	Continued From page 6 medication cupboard to administer medications. The surveyor observed a Lantus insulin pen open and in use, but it had no open or expiration date noted on the insulin pen. On July 9, 2024, at 8:42 a.m. ULP-F opened R4's locked medication cupboard to administer medications. The surveyor observed a Lantus insulin pen, but it had no open or expiration date noted on the insulin pen. On July 9, 2024, at 9:36 a.m. the surveyor observed R6's medication cupboard with clinical nurse supervisor (CNS)-B and noted the following medications open and in use: - latanoprost eye drops had no open or expire date noted on the bottle or the box; - Lantus insulin had no open or expire date on the pen; and - Humalog KwikPen had not open or expire date on the pen. On July 9, 2024, at 9:36 a.m. CNS-B stated time sensitive medications should be dated when they are opened and used per manufacturer instructions. The licensee's Medication Storage policy dated July 2024, indicated medications will be stored consistent with manufacturer's recommendations. Lantus insulin prescribing information dated June 2024, identified "Only use your pen for up to 28 days after its first use. Throw away the LANTUS SoloStar pen you are using after 28 days, even if it still has insulin left in it." Latanoprost prescribing information dated August 2011, identified "Once a bottle is opened for use, it may be stored at room temperature up to 25°C	01890		

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01890	Continued From page 7 (77°F) for 6 weeks." Humalog KwikPen prescribing information dated March 2013, identified "The HUMALOG Pen you are using should be thrown away after 28 days, even if it still has insulin left in it." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and	01940		

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01940	Continued From page 8 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R7 had diagnoses to include dementia. On July 9, 2024, at 7:37 a.m. unlicensed personnel (ULP)-H and ULP-I assisted R7 with application of compression stockings. R7's provider orders dated June 17, 2024, included an order for compression stockings on lower legs during the day. R7's Individualized Treatment and Therapy Plan dated June 17, 2024, included compression stockings applied to R7's lower legs in morning and removed at bedtime.	01940		

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01940	Continued From page 9 R7's service plan dated July 2, 2024, did not include treatment of compression stockings. On July 10, 2024, at 12:01 p.m. registered nurse (RN)-D stated compression stockings were not included on July 1, 2024's, service plan. RN-D stated the service plan was printed on June 14, 2024, and the change didn't come into effect until June 17, 2024, per provider's orders. The licensee's Therapy Management Plan policy dated August 2021, indicated for each resident at the licensee receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: The licensee failed to ensure medications were administered according to policy and accepted	02320		

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02320	Continued From page 10 standards of practice for one of one resident (R5) with eye ointment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 9, 2024, at 9:30 a.m. unlicensed personnel (ULP)-G was observed administering medications to R5. ULP-G removed a tube of Genteal eye ointment, opened the tube, and placed a small amount of the eye ointment on the glove. ULP-G held R5's left eye opened and rubbed the ointment on the eye, the eyelid, and under the eye. ULP-G repeated the process, using the same gloved finger on the right eye. On July 9, 2024, at 9:43 a.m. clinical nurse supervisor (CNS)-B stated eye ointment should have been applied in a bead directly into the eye, not placed on gloves to put in the eye. In addition, R5 had a history of shingles in the eye, so ULP-G should not have touched one eye and then touched the other eye due to cross contamination. The licensee's undated Eye Drop/Ointment Procedure identified: "a. Apply gloves b. Cleanse the area prior to medication administration if necessary. i. If this was needed, change gloves and	02320		

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02320	Continued From page 11 perform hand hygiene before proceeding to the next step c. Have the resident tilt his/her head backwards; d. Gently pull down on the lower lid with your index finger to expose the eye e. Apply a ½-inch ribbon, or amount as ordered on the MAR, of ointment into the appropriate eye i. Do not touch the eye with the tip of the ointment tube. ii. Apply the ointment to the lower conjunctival sac (the inside of the lower eyelid, moving from inner to outer aspect of the eyelid) iii. Use a tissue to wipe any extra f. Have the resident close his/her eyelid and encourage them to keep it closed for 1-2 minutes g. Repeat In the other eye, if ordered 8. Properly dispose of gloves and wash hands using a sink or hand sanitiz [sp] appropriate 9. Document the administration on the MAR" The Genteal Tears eye ointment label dated December 2023, identified the directions for use were to "Pull down the lower lid of the affected eye and apply a small amount (one-fourth inch) of ointment to the inside of the eyelid. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *07/09/24*
Time: 12:13:07
Report: 7935241025

Food and Beverage Establishment Inspection Report

Location:
Scandi Haven Village
1710 Mckinney Avenue
Benson, MN56215
Swift County, 76

Establishment Info:
ID #: 0038885
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3208434728
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 172 Degrees Fahrenheit
Location: Dish Machine - MC
Violation Issued: No

Hot Water: = at 171 Degrees Fahrenheit
Location: Dish Machine - AL
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizing Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Cooler - MC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Cooler - AL
Violation Issued: No

Process/Item: Hot Holding
Temperature: 175 Degrees Fahrenheit - Location: Eggs
Violation Issued: No

Process/Item: Hot Holding
Temperature: 150 Degrees Fahrenheit - Location: Pancakes
Violation Issued: No

Type: Full
Date: *07/09/24*
Time: 12:13:07
Report: 7935241025
Scandi Haven Village

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 160 Degrees Fahrenheit - Location: Oatmeal
Violation Issued: No

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

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

I acknowledge receipt of the MN Department of Health inspection report number 7935241025 of 07/09/24.

Certified Food Protection Manager: Mandy Flannigan

Certification Number: 81399 Expires: / /

Signed: _____
Establishment Representative

Signed: Rebecca Tonneson
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us