DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 4, 2022

Administrator
Clark Crossings Of Wells
351 2nd Avenue Northwest
Wells, MN 56097

RE: Project Number(s) SL35684015

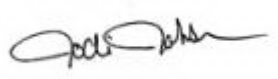
Dear Administrator:

On October 20, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the June 8, 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
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 26, 2022

Administrator
Clark Crossings Of Wells
351 2nd Avenue Northwest
Wells, MN 56097

RE: Project Number(s) SL35684015

Dear Administrator:

On August 19, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on June 8, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the June 8, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on June 8, 2022, found not corrected at the time of the August 19, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1290-Background Studies Required-144g.60 Subdivision 1 = $3,000

The details of the violations noted at the time of this follow-up evaluation completed on August 19, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **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
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

authorized in §144G.20.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

Jodi Johnson, Supervisor
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35684	A. BUILDING: _____ B. WING _____	R 08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK CROSSINGS OF WELLS	351 2ND AVENUE NW WELLS, MN 56097

(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 a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. SL35684015-1 On, August 18, 2022, through August 19, 2022, surveyors with the Minnesota Department of Health conducted a follow-up survey to verify correction of order(s) issued at the time of the June 8, 2022, licensing survey. As a result of the follow-up survey, the following order have been reissued. On August 19, 2022, at 10:34 a.m. an immediate correction order was issued for SL20987015, tag identification 2310 at a level 3, widespread (I).	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	{0 510}		

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{0 510}	Continued From page 1 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: No further action required.	{0 510}		
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: No further action required.	{0 580}		

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{0 660}	Continued From page 2	{0 660}		
{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 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: No further action required.	{0 660}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		

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{0 810}	Continued From page 3	{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: No further action required.	{0 810}		

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{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	{0 900}		

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{0 900}	Continued From page 5 No further action required.	{0 900}		
{01290} SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was completed prior to staff providing services, for two of two employees (unlicensed personnel (ULP)-M and ULP-N) with records reviewed. This had the potential to affect all residents. This resulted in an immediate correction order on August 19, 2022, at 10:34 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	{01290}		

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{01290}	Continued From page 6	{01290}		

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

The findings include:

ULP-M
ULP-M began providing cares under the Assisted Living with Dementia Care license for the licensee on May 6, 2022.

The licensee lacked evidence a background study had been completed prior to ULP-M providing care and services to the residents.

The licensee's schedule was reviewed for ULP-M. For the month of August 2022, ULP-M worked on August 1, 2, 3, 5, 6, 7, 9, 13, 14, 15, 16, and 17.

ULP-N
ULP-N began providing cares under the Comprehensive home care license on April 16, 2021, and under the Assisted Living with Dementia Care license beginning August 1, 2021.

The licensee lacked evidence a background study had been completed prior to ULP-N providing care and services to the residents.

The licensee's schedule was reviewed for ULP-N. For the month of August 2022, ULP-N worked on August 1, 2, 3, 4, 8, 9, 10, 11, 12, 17, and 18.

An E-mail received from licensed assisted living director (LALD)-A on August 19, 2022, at 9:18 a.m. identified ULP-M and ULP-N had not completed the process for background checks. It had been initiated by human resources staff, and the employees were to complete the consent within a certain time frame. This was not

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{01290}	Continued From page 7 completed and therefore, the background study application was closed. On August 19, 2022, at 10:34 a.m. LALD-A confirmed ULP-M and ULP-N would have direct contact with residents during their scheduled shifts. The licensee's Background Checks policy dated August 1, 2021, identified all employees, contractors, and regularly scheduled volunteers of the facility with direct resident contact must pass a background study. "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor and review by evaluation supervisor on August 19, 2022, however non-compliance remains at level 3, widespred (I). TIME PERIOD FOR CORRECTION: Two (2) days	{01290}		
{01470} SS=F	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	{01470}		

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{01470}	Continued From page 8	{01470}		

of assisted living services by the individual staff person;
(3) handling of emergencies and use of emergency services;
(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);
(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;
(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and
(9) a review of the types of assisted living services the employee will be providing and the 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;

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{01470}	Continued From page 9 (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: No further action required.	{01470}		
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and	{01500}		

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{01500}	Continued From page 10 reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required.	{01500}		

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{01760}	Continued From page 11	{01760}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action required.	{01760}		
{01890} SS=D	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: No further action required.	{01890}		
{02110} SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures	{02110}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35684	A. BUILDING: _____ B. WING _____	R 08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK CROSSINGS OF WELLS	351 2ND AVENUE NW WELLS, MN 56097

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{02110}	Continued From page 12 required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: No further action required.	{02110}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK CROSSINGS OF WELLS	**351 2ND AVENUE NW WELLS, MN 56097**

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Minnesota Dept. of Health

Mankato

Type: Full
Date: *06/07/22*
Time: 11:56:14
Report: 1028221104

Food and Beverage Establishment Inspection Report

Location:
Clark Crossings Of Wells
351 2nd Avenue Nw
Wells, MN56097
Faribault County, 22

Establishment Info:
ID #: 0037785
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5075535004
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

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: 3-Compartment Sink
Violation Issued: No

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: Sausage
Violation Issued: No

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

Process/Item: Hot Holding
Temperature: 138 Degrees Fahrenheit - Location: Pork
Violation Issued: No

Type: Full
Date: *06/07/22*
Time: 11:56:14
Report: 1028221104
Clark Crossings Of Wells

Food and Beverage Establishment Inspection Report

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

This Inspection was conducted in conjunction with HRD.

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221104 of 06/07/22.

Certified Food Protection Manager: Terri Varnis

Certification Number: FM13259 Expires: 01/16/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Amber Loe
Culinary Aide

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

Electronically Delivered

July 8, 2022

Administrator
Clark Crossings of Wells
351 2nd Avenue Northwest
Wells, MN 56097

RE: Project Number SL35684015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 8, 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 Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

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

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order 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 resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

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

Free from Maltreatment reconsideration requests should 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

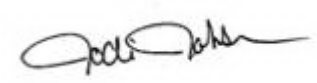
REQUESTING A HEARING

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

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

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

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL#35684015 On June 6, 2022, through June 8, 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 13 residents; 12 receiving services under the provider's Assisted Living with Dementia Care license. 1290: An immediate correction order was issued on June 8, 2022. The immediacy was removed; however non-compliance remains at a level 3, islated scope (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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 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 deficient practice had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 all staff, residents, and visitors.) The findings include: The licensee failed to ensure employees in direct contact with residents were wearing appropriate personal protective equipment (PPE) as per the Centers for Disease Controls (CDC) and Minnesota Department of Health (MDH)	0 510		

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0 510	Continued From page 2 guidelines. The Minnesota Department of Health (MDH) document dated April 7, 2022, titled COVID-19 PPE and Source Control Grids for Congregate Care Settings by Community Transmission Level reads: "PPE grid for health care workers, direct service providers (i.e. includes employees, contractors, volunteers, etc.); when community transmission levels are high or substantial, those working with residents without suspected or confirmed SARS-CoV-2 infection should wear a face mask (source control) and eye protection. The Centers for Disease Control (CDC) Integrated County View Data Tracker for COVID-19 listed the COVID-19 community transmission rate as "high" for Faribault County at the time of the survey. On June 6, 2022, at 10:33 a.m. unlicensed personnel (ULP)-E was observed speaking to a resident in the hallway. ULP-E wore a surgical face mask, but no eye protection. On June 6, 2022, at 12:11 p.m. ULP-L was observed serving ice cream to residents sitting in the dining room. ULP-L wore a surgical face mask, but no eye protection. On June 6, 2022, at 3:30 p.m. ULP-I was observed to transfer R4 from the couch into her wheelchair. ULP-I wore a surgical face mask, but no eye protection. On June 6, 2022, at 4:18 p.m. ULP-J was observed to transfer R4 from a wheelchair onto a couch in the common living area. ULP-J wore a surgical face mask, but no eye protection.	0 510		

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0 510	Continued From page 3	0 510		

On June 7, 2022, at 10:24 a.m. ULP-K and ULP-F were observed applying fingernail polish to R2 and R8's fingernails. Both ULP-K and ULP-F wore surgical face masks but lacked eye protection.

On June 7, 2022, at 11:31 a.m. registered nurse (RN)-C stated staff should wear a surgical face mask and eye protection when they are near residents or have the potential to be near residents. RN-C stated this would include walking down the hallway, in the dining area, and doing any direct care with residents. RN-C added she had also noticed staff were not consistently wearing eye protection.

On June 7, 2022, at 11:35 a.m. ULP-E was observed to check R1's blood sugar and administer insulin. ULP-E wore a surgical face mask, but lacked eye protection.

On June 7, 2022, at 11:47 a.m. ULP-E confirmed she did not have eye protection on when checking R1 blood sugar and administering insulin. ULP-E stated eye protection was available to staff and she should have been wearing for resident contact.

On June 7, 2022, at 12:15 p.m. licensed practical nurse/licensed assisted living director (LPN/LALD)-A stated she was aware of county transmission levels and that Faribault County was listed as "high." LPN/LALD-A verified staff should be wearing eye protection when in contact with residents.

The licensee's Universal Eye Protection policy dated March 25, 2022, indicated the licensee would follow MDH and CDC recommendations regarding universal use of eye protection as

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0 510	Continued From page 4 personal protective equipment (PPE). Use of eye protection would follow the community transmission rate for the county in which the facility is located. County transmission rates would be checked weekly, and the use of universal eye protection would continue until a lower transmission rate is reached for two consecutive weeks. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current clients, staff, and visitors.	0 580		

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0 580	Continued From page 5 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 June 8, 2022, at 9:40 a.m. licensed practical nurse/licensed assisted living director (LPN/LALD)-A indicated prior to her employment approximately five months earlier the management had left abruptly. LPN/LALD-A stated she did not inherit any notes or type of quality assurance. This was further confirmed by vice president of assisted living (VP)-D who stated quality assurance had not been the number one priority to implement in the facility. The licensee's Quality Management Plan policy undated, noted the LALD would establish a quality management program to develop and maintain the licensee's continuous performance improvement efforts. Documentation of meetings would be retained for two years and made available to the commissioner at the time of survey, investigation, or renewal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 6 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for one of two employees (licensed practical nurse/licensed assisted living director (LPN/LALD)-A) 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).	0 660		

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0 660	Continued From page 7 The findings include: The licensee's TB risk assessment dated May 10, 2022, indicated the licensee was a low risk. LPN/LALD-A was hired January 10, 2022, to provide supervision and direct care services. On June 6, 2022, at 3:00 p.m. LPN/LALD-A was observed interacting with residents that were sitting in the east dining area having juice and snacks. LPN/LALD-A's employee record contained a negative two-step TB skin test dated December 22, 2021, and December 31, 2021; however, LPN/LALD's employee record lacked evidence of the following: - TB history and symptom screening On June 8, 2022, at 12:30 p.m. LPN/LALD-A confirmed her employee file was lacking the TB history and symptom screening. LPN/LALD-A indicated the two-step TB skin test had been completed at a local clinic and she assumed all pieces for the TB requirement would have been met. The licensee's TB Prevention and Control policy dated August 1, 2021, identified at the time of hire and prior to any contact with residents, all assisted living employees and all volunteers will be screened for Tuberculosis. Screening included: 1. Assessing for current symptoms of active TB; 2. Assessing for TB risk factors and TB history; 3. Testing for TB by administering either a two-step TB skin test or single Interferon-Gamma	0 660		

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	35684	A. BUILDING: _____ B. WING _____	06/08/2022

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0 660	Continued From page 8 Release Assays (IGRA) (blood tests that can aid in diagnosing Mycobacterium tuberculosis infection). The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation	0 800		

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0 800	Continued From page 9 regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On June 8, 2022, between 2:30 p.m. and 4:00 p.m. survey staff toured the facility with Director of Maintenance (DM)-H. During the facility tour, survey staff observed emergency lighting to be in disrepair and the battery power nonfunctioning. Survey staff also observed mismarked exit doors in the dementia care living wing of the facility. The door leading to the enclosed outside area marked as EXIT, must be changed to NO EXIT. At that same time, DM-H verbally confirmed the observations noted above. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 10 (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 licensee failed to provide the required fire safety training for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 11 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On June 8, 2022, between 2:30 p.m. and 4:00 p.m. survey staff toured the facility with Director of Maintenance (DM)-H. Survey staff requested fire safety training and fire drill documentation, but the licensee could not provide the requested documentation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to	0 900		

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0 900	Continued From page 12 the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract prior to providing assisted living services for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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:	0 900		

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0 900	Continued From page 13 R1 began receiving assisted living services on August 1, 2021. R1's Service Plan dated July 9, 2021, indicated R1 received services, which included bathing, grooming, dressing, blood glucose checks, and medication administration. On June 7, 2022, at 11:35 a.m. unlicensed personnel (ULP)-E was observed to check R1's blood sugar and administer insulin. R1's record lacked evidence an assisted living contract was received by R1. On June 7, 2022, at 2:00 p.m. licensed practical nurse/licensed assisted living director (LPN/LALD)-A verified R1 was lacking a contract. LPN/LALD-A stated R1 had a Residency Agreement dated July 9, 2021, but had never gotten the updated contract that was required after August 1, 2021. LPN/LALD-A included she was unaware of this until now as previous management was here during the implementation of the new contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 970 SS=A	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or	0 970		

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0 970	Continued From page 14 unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for one of two residents (R2) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's assisted living contract dated April 4, 2022, included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. -Page 15, section 2 of the contract indicated: Resident would indemnify and hold harmless the provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or	0 970		

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0 970	Continued From page 15 agents. -Page 15, section 4 of the contract indicated: Provider is not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurred as a result of an equipment malfunction or hazardous conditions within the building not caused by the resident or resident's guests. On June 7, 2022, at 3:30 p.m. licensed practical nurse/licensed assisted living director (LPN/LALD)-A and vice president of assisted living (VP)-D verified R2's contract included the above content. LPN/LALD-A and VP-D stated the licensee had recently received a revised contract from their attorney but had not gotten it to R2 yet. The licensee lacked a policy for Assisted Living Licensure contract requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be	01290		

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01290	Continued From page 16 classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study was completed prior to staff providing services, for one of two employees (licensed practical nurse/licensed assisted living director (LPN/LALD)-A) with records reviewed. This resulted in an immediate correction order on June 8, 2022, at approximately 10:25 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: LPN/LALD-A began providing assisted living with dementia care services for the licensee on January 10, 2022. The licensee lacked evidence a background study had been completed prior to LPN/LALD-A providing care, services, and supervision of unlicensed personnel (ULP) and residents.	01290		

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01290	Continued From page 17 On June 6, 2022, at 3:00 p.m. LPN/LALD-A was observed interacting with residents that were sitting in the east dining area having juice and snacks. On June 8, 2022, at 10:16 a.m. office coordinator (OC)-G stated there was not a background study clearance form in LPN/LALD-A's employee file. OC-G stated someone else had completed LPN/LALD's hiring paperwork and was not aware a background study had not been completed until gathering the information for the surveyor. OC-G stated audits were done to ensure all required paperwork was completed, but LPN/LALD-A's file had not ever been audited. The licensee's Background Checks policy dated August 1, 2021, identified all employees, contractors, and regularly scheduled volunteers of the facility with direct resident contact must pass a background study. "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program. A licensed assisted living director is required to also have a deeper background check through the Board of Executives for Long-Term Services and Supports (BELTSS) licensing board process. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On June 8, 2022, at 12:51 p.m. the immediacy of correction order 1290 was removed; however, non-compliance remains at a level 3/isolated. TIME PERIOD FOR CORRECTION: Two (2) Days	01290		

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01470	Continued From page 18	01470		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the 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	01470		

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01470	Continued From page 19 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 one of one employee (unlicensed personnel (ULP)-E) received orientation to assisted living facility licensing requirements and regulations before providing services 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: ULP-E was hired on January 20, 2021, to provide	01470		

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01470	Continued From page 20 assisted living with dementia care services. ULP-E's record lacked evidence of receiving orientation to assisted living with dementia care to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the 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; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On June 8, 2022, at 12:10 p.m. office coordinator (OC)-G indicated the previous manager had not made it clear that all employees hired prior to August 1, 2021, would also need to complete the assisted living orientation. OC-G stated all new employee since August 2021, have completed the	01470		

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01470	Continued From page 21 training, but none of the older employees have had it, including ULP-E. The licensee's Assisted Living and Assisted Living with Memory Care Orientation - All Staff policy dated August 1, 2021, included: all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and	01500		

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	35684	A. BUILDING: _____ B. WING _____	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK CROSSINGS OF WELLS	351 2ND AVENUE NW WELLS, MN 56097

(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
01500	Continued From page 22 reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of	01500		

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01500	Continued From page 23 employment for one of two employees (unlicensed personnel (ULP)-E) 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: ULP-E had a start date of January 20, 2021, and began providing assisted living services on August 1, 2021. ULP-E's employee training records lacked evidence ULP-E had successfully completed annual training as required in the following area: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of infection control techniques; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On June 8, 2022, at 2:00 p.m. office coordinator (OC)-G confirmed ULP-E lacked the required annual training. OC-G indicated the courses had been assigned to ULP-E to complete, but there was no current tracking system in place to ensure staff completed.	01500		

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01500	Continued From page 24 The licensee's Assisted Living and/or Assisted Living with Memory Care Annual Training policy dated August 1, 2021, included all assisted living employees would complete annual education on the following topics: - reporting of maltreatment of vulnerable adults under section 626.557; - infection control techniques used in the home and implementation of infection control standards; - review of policies and procedures relating to the provision of assisted living services and how to implement; - principles of person-centered planning and service delivery; - how person-centered planning and service delivery applies to direct support services provided by staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01650 SS=A	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	01650		

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01650	Continued From page 25 (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 two residents (R1) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Service Plan dated July 9, 2021, indicated R1 received services, which included bathing, grooming, dressing, blood glucose checks, and medication administration.	01650		

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01650	Continued From page 26 On June 7, 2022, at 11:35 a.m. unlicensed personnel (ULP)-E was observed to check R1's blood sugar and administer insulin. R1's Service Plan lacked the following: - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the resident; and - the schedule and methods of monitoring staff providing services. On June 7, 2022, at 2:00 p.m. licensed practical nurse/ licensed assisted living director (LPN/LALD)-A verified the content was lacking on R1's service plan and stated R1 had an old version of the service plan. LPN/LALD-A indicated their new service plan had all the required content and was not sure why R1's had not been updated with the form change. The licensee's Contents of Service Plans policy, dated August 1, 2021, noted the service plan would include: - schedule and methods of monitoring assessments; and - schedule and methods of monitoring staff providing services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 27 living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for one of three residents (R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6's Service Plan (Waiver) - Addendum to Contract dated May 1, 2022, identified services included medication administration. R6's prescriber's orders dated February 14, 2022, included Systane Complete solution 0.6% (lubricating eye drop medication) and directed to	01760		

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01760	Continued From page 28 instill one drop in each eye, three times daily after meals at 9:00 a.m., 1:00 p.m., and 7:00 p.m. On June 7, 2022, at 11:48 a.m. the surveyor observed unlicensed personnel (ULP)-E obtain R6's Systane eye drops from the medication cart for administration. ULP-E entered R6's room, applied gloves and administered one drop to each eye. ULP-E removed gloves, sanitized hands and proceeded back to the medication cart where ULP-E documented eye drop administration on R6's electronic medication administration record (eMAR). When interviewed at this time, ULP-E verified she had administered the eye drop prior to R6's meal, and more than one hour before the scheduled time. ULP-E stated she always administered the eye drop before breakfast and lunch because R6 like to clear off the tables after the meals. ULP-E stated prescribed medications could only be given one hour before or after the scheduled time. On June 7, 2022, at 3:35 p.m. licensed practical nurse/ licensed assisted living director (LPN/LALD)-A stated giving a an ordered medication one hour before or after the scheduled time was a medication error. LPN/LALD-A indicated a medication error report would be completed. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 21, 2021, instructed medications, treatment and therapy always need to be administered according to the "6 Rights". a. Right person b. Right medication, treatment, or therapy c. Right time d. Right route e. Right dose	01760		

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01760	Continued From page 29 f. Right chart/record to document that the medication, treatment, and therapy was taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label for one of one resident (R1). 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 June 7, 2022, at 9:43 a.m. the licensee's west medication cart was reviewed with unlicensed	01890		

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01890	Continued From page 30 personnel (ULP)-E. R1's opened aspart insulin pen 100 unit/milliliter (ml) lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. ULP-E stated she knew it was R1's insulin pen because it was within the plastic divider where R1's other insulin was kept. ULP-E stated R1's medications came from the veteran affairs (VA) pharmacy and didn't always have individual labels on the pen, but indicated the plastic baggie they come in might. On June 7, 2022, at 9:50 a.m. registered nurse (RN)-C confirmed all medications should have original labels and this would include bulk medications that come from the VA. RN-C stated the insulin should be labeled with resident's name and kept in baggie with prescription information. The licensee's Storage of Medications policy dated August 1, 2021, indicated until the medication is set up for immediate or later administration by a nurse a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		

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02110	Continued From page 31	02110		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110		

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02110	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for two of two residents (R1, 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) 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 included: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. R1 and R2's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;	02110		

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02110	Continued From page 33 - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On June 7, 2022, at 1:21 p.m. licensed practical nurse/licensed assisted living director (LPN/LALD)-A stated she was aware of this requirement as a "sister facility" had been cited for the same thing. LPN/LALD-A stated the policies had been developed but not implemented at this facility yet. LPN/LALD-A verified none of the current residents had received the required policies. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *06/07/22*
Time: 11:56:14
Report: 1028221104

Food and Beverage Establishment Inspection Report

Location:
Clark Crossings Of Wells
351 2nd Avenue Nw
Wells, MN56097
Faribault County, 22

Establishment Info:
ID #: 0037785
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5075535004
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

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: 3-Compartment Sink
Violation Issued: No

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: Sausage
Violation Issued: No

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

Process/Item: Hot Holding
Temperature: 138 Degrees Fahrenheit - Location: Pork
Violation Issued: No

Type: Full
Date: *06/07/22*
Time: 11:56:14
Report: 1028221104
Clark Crossings Of Wells

Food and Beverage Establishment Inspection Report

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

This Inspection was conducted in conjunction with HRD.

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221104 of 06/07/22.

Certified Food Protection Manager: Terri Varnis

Certification Number: FM13259 Expires: 01/16/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Amber Loe
Culinary Aide

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