Electronically Delivered

October 31, 2022

Administrator
American Eagle Owatonna
364 Cedardale Drive Southeast
Owatonna, MN 55060

RE: Project Number(s) SL30823015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 5, 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, no immediate fines are assessed.

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

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
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
	30823	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	364 CEDARDALE DRIVE SE OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30823015 On, October 3, 2022, through October 5, 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 23 residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 4, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 510	Continued From page 2	0 510		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure infection control standards were followed for one of three unlicensed personnel (ULP-C) while administering medications. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 October 3, 2022, at approximately 12:30 p.m. ULP-C was observed passing medication to R5, R6, R2 and R7 without washing or sanitizing their	0 510		

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0 510	Continued From page 3 hands. ULP-C reviewed R5's record; placed medication in medication cup, and left the medication room. ULP-C entered R5's room, administered the medication, and left the room. ULP-C unlocked the medication room door to document the medication administration in R5's record. ULP-C reviewed R6's record, placed medication in the medication cup, and left the medication room to enter R6's room and administer the medication. ULP-C left R6's room and returned to the medication room. ULP-C continued the same process with R2 and R7. ULP-C did not cleanse or sanitize their hands before or after each resident's medication administration or when entering the medication room. On October 3, 2022, at 1:16 p.m. ULP-C indicated that the hand sanitizer was located on the wall in the medication closet and should be used when entering the room. On October 3, 2022, at 3:00 p.m. licensed assisted living director (LALD)-A indicated the expectation for medication passing was to use the hand sanitizer on the wall directly inside the medication room, immediately upon entering that room. The licensee's Infection control policy dated September, 27, 2022, indicted they would follow the current guidelines from CDC for prevention control in long-term care facilities. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 680	Continued From page 4	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness (EP) plan with all of the required content. In addition, the licensee failed to perform the frequency of inspection, maintenance, and load test requirements for the emergency power generator as part of the	0 680		

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0 680	Continued From page 5 emergency plan to ensure the proper performance of the generator. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on October 3, 2022, at approximately 10:00 a.m., a request was made to view the licensee's emergency preparedness plan (EPP). Licensed assisted living director (LALD)-A indicated that they were currently working on Appendix Z and did not have it completed. THE EMERGENCY PREPAREDNESS PLAN The Emergency Preparedness Plan lacked the following required content: - a comprehensive program to include infectious diseases and pandemics; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies including surge	0 680		

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0 680	Continued From page 6 planning and use of volunteers; - the facility's role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities, volunteers; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. EMERGENCY GENERATOR On October 4, 2022, at approximately 3:00 p.m. survey staff interviewed LALD-A and the director of engineering (DOE)-F about the emergency generator and requested records relating to the emergency generator inspections, maintenance, and load test runs. The record provided for review indicated the licensee failed to provide the required minimum frequency of weekly inspections, maintenance, and monthly load test records as required to meet the requirements for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator. The generator inspection records showed inspections were performed monthly rather than weekly, and no other records were available.	0 680		

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0 680	Continued From page 7 On October 4, 2022, at approximately 3:15 p.m. during the exit interview with engineering, LALD-A and DOE-F acknowledged the above findings regarding the emergency generator. DOE-F stated the emergency generator was set to run weekly, but they did not know how to locate records and therefore, were not able to produce the load test runs. On October 5, 2022, at 11:00 a.m. LALD-A confirmed they were just surveyed on their Assisted Living side and cited for not completing the emergency preparedness plan, and have not had a chance to make any changes to their EPP manual. The licensee's Emergency Preparedness policy date September 27, 2022, noted they plan to be aligned with the Centers of Medicare and Medicaid Services State Operation Manual Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 4, 2022, approximately from noon to 2:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A and Director of Engineering (DOE)-F. During the tour, survey staff observed the following: 1) In resident room B22, the heating system had damaged and exposed radiant fins. 2) In resident room B20, the exhaust fan did not operate when turned on. 3) No carbon monoxide detection system was provided for a centralized system for compliance with carbon monoxide detection in buildings with fuel-burning equipment/appliances in the mechanical room for the safety of residents. This applies to multifamily dwellings with sleeping units that do not contain fuel burning applies within the units. 4) The 1-hour fire-rated door near the front (near fireplace) was in an open position with a door stopper.	0 800		

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0 800	Continued From page 9 On October 4, 2022, at approximately 3:15 p.m., during the exit interview, the LALD-A and the DOE-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

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0 810	Continued From page 10	0 810		

twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.

This MN Requirement is not met as evidenced by:
Based on record review and interview, the licensee failed to provide the complete content on the fire safety and evacuation plan, the minimum frequency of employee fire safety and evacuation drills, and the minimum required staff training on fire safety and evacuation. This has the potential to directly affect the safety of visitors, staff, and all residents receiving care.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On October 4, 2022, at approximately 3:00 pm, survey staff received the facility fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-A and the director of engineering (DOE)-F. Document review and interview with the LALD-A and the DOE-F at approximately 3:15 p.m. indicated the following findings:

FIRE SAFETY AND EVACUATION PLAN
The fire safety and evacuation plan lacked complete fire protection procedures necessary to

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0 810	Continued From page 11 address unique resident-specific situations during an evacuation from fire or similar emergency. Unique situations that must be considered during an evacuation could be residents who have mobility limitations, cognitive impairment, deaf or blind, or any residents needing assistance for movement during an evacuation that must be addressed in the fire safety and evacuation plan. TRAINING The licensee lacked a record of employee training specifically on the fire safety and evacuation plan in accordance with Minnesota Statutes required upon hire and at least twice a year thereafter. FIRE and EVACUATION DRILLS The licensee failed to provide the minimum required evacuation drills for compliance with two evacuation drills per year per shift with at least one drill every other month for a total minimum of six evacuation drills per year. The drill record review showed fire drills performed, but the records lacked evacuation drill information. Survey staff explained that employee fire drills must also include evacuation drills. Fire safety and evacuation drills may be performed at the same time and be recorded as such. On October 4, 2022, at approximately 3:15 p.m., during the exit interview, the LALD-A and the DOE-F verified and acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		

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	30823	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	364 CEDARDALE DRIVE SE OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 910	Continued From page 12	0 910		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of three residents (R3, R4). This had the potential to affect all 22 residents living in the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a written contract with the following required content: -the contract must include in a conspicuous place and manner on the contract the license number or Health Facility Identification (HFID) number of	0 910		

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0 910	Continued From page 13 the facility; -the contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: -the facility and contracted service provider when applicable; -the licensee of the facility; -the managing agent of the facility, if applicable; and -the authorized agent for the facility. R3 R3's Residency and Services Agreement dated December 30, 2021, indicated the licensee was registered by the State of Minnesota as a "Housing With Services establishment," and lacked the license number of the facility. In addition, the contract did not include the name, telephone number, or the physical mailing address of the managing agent or the authorized agent. R4 R4's Residency and Services Agreement dated August 3, 2022, indicated the licensee was registered by the State of Minnesota as a "Housing With Services establishment," and lacked the license number of the facility. In addition, the contract did not include the name, telephone number, or the physical mailing address of the managing agent or the authorized agent. On October 4, 2022, at 2:30 p.m. licensed assisted living director (LALD)-A confirmed the missing items in the contract and indicated their legal team was still working on making the required regulatory changes. No further information was provided.	0 910		

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0 910	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of three residents (R3, R4). This had the potential to affect all 22 residents living within the assisted living facility. This practice resulted in a level one violation (a	0 930		

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0 930	Continued From page 15 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R3 R3's residency and services agreement signed December 30, 2021, lacked the following content: -the name and contact information of the person representing the facility who is designated to handle and resolve complaints; -the right under section 144G.54 to appeal the termination of an assisted living contract; -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which a resident consent is required for a transfer; and -contact information for the Office of Ombudsman for Long-Term Care, Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. R4 R4's residency and services agreement signed August 3, 2022, lacked the following content: -the name and contact information of the person representing the facility who is designated to handle and resolve complaints; -the right under section 144G.54 to appeal the termination of an assisted living contract; -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which a resident consent is required for a	0 930		

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0 930	Continued From page 16 transfer; and -contact information for the Office of Ombudsman for Long-Term Care, Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. On October 4, 2022, at 2:30 p.m. licensed assisted living director (LALD)-A confirmed the missing items in the contract and indicated that their legal team was aware and was still working on making the required regulatory changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 970 SS=C	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 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 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 22 residents living within the assisted living facility.	0 970		

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0 970	Continued From page 17 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 3, 2022, at approximately 10:00 a.m. during the entrance conference, the surveyor requested a copy of the licensee's assisted living contract. The licensee's Residency and Services Agreement (contract) included a clause on page 12, section B, "Risk Agreement. You are responsible for your personal, financial and health care decisions. You are also responsible for maintaining health, personal property, liability, automobile (if applicable), and other insurance coverage in adequate amounts. You agree to obtain insurance in an amount adequate to cover your personal property and your general liability. You acknowledge that we do not insure your person or property." In addition, on page 13, section 10, "You understand and agree to assume the risks inherent in this Agreement. You agree to hold us, our associates and agents harmless for any damages, injury or other loss resulting from: (1) reasonable acts or omissions made in good faith; (2) action by a third party, fire, water, theft or the elements; or (3) loss of personal property." On October 4, 2022, at 2:30 p.m. licensed assisted living director (LALD)-A confirmed all resident contracts contained the same language	0 970		

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0 970	Continued From page 18 and indicated that their legal team was still working on making the required regulatory changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620		

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01620	Continued From page 19 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool on day 14 day for one of three residents (R3) as required. 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: R3 began receiving assisted living services on January 17, 2022. R3's service plan dated August 16, 2022, indicated R3 received services to include assistance with medication administration and activities of daily living (ADLs). R3's record included an initial assessment dated January 17, 2022, and a reassessment dated February 16, 2022, which was 30 days after the start of services (16 days late). On October 4, 2022, at 11:15 a.m. registered nurse (RN)-B confirmed R3's record lacked a 14-day assessment and was aware that assessments should be completed initially, at 14-days, and every 90 days thereafter. The licensee's undated, Ongoing Resident Assessment policy, indicated the resident will be reassessed at 30 days and lacked the required	01620		

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01620	Continued From page 20 regulatory language indicating a reassessment must be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those	01650		

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01650	Continued From page 21 chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for three of three residents (R2, R3, R4). 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: R2 R2's service plan dated October 20.2021, indicated R2 received assistance with bathing, dressing, medication management and toileting. R2's service plan lacked the following required content: - the identification of staff or categories of staff who will provide the services. - the schedule and methods of monitoring assessments of the resident. - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided. - information and a method to contact the facility; and - the names and contact information of	01650		

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01650	Continued From page 22 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. R3 R3's service plan dated May 10,2022, indicated R3 received assistance with bathing, toileting, medication management and transfers. R3's service plan lacked the following required content: - the identification of staff or categories of staff who will provide the services. - the schedule and methods of monitoring assessments of the resident. - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided. - information and a method to contact the facility; and - 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. R4 R4's service plan dated August 3, 2022, indicated R4 received assistance with bathing, dressing, medication management and behavior management. R4's lacked the following required content: - the identification of staff or categories of staff	01650		

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01650	Continued From page 23 who will provide the services. - the schedule and methods of monitoring assessments of the resident. - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided. - information and a method to contact the facility; and - 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. On October 4, 2022, at 12:40 p.m. registered nurse (RN)-B stated being aware of the required service plan contents, and admitted the service plans lacked the required contents. The licensee's 6.08 Service plan policy dated September 28, 2022, indicated a service plan will include the required content in 144G.50 Subd. 1 and 144G.70 Subd. 4. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues	01710		

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01710	Continued From page 24 that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on October 3, 2022, at 10:00 a.m. licensed assisted living director (LALD)-A and RN-B stated the licensee provided medication management services to the residents at the facility. R2's records lacked evidence the RN conducted an annual review of all medications the resident was known to be taking to include a review of the side effects and contraindications since October 20, 2020. R2's diagnosis included unspecified dementia, anxiety, and major depressive disorder. R2's service plan dated October 20, 2021, indicated R2 received services which included medication administration as ordered by his	01710		

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01710	Continued From page 25 primary provider. R2's medication administration record indicated the following scheduled medication: divalproex (used for dementia), levothyroxine (used for low thyroid levels), Namenda (used for dementia), acetaminophen (for pain), buspirone (used for anxiety). On October 4, 2022, at 12:40 a.m. RN-B confirmed R2 was missing a current annual medication assessment and the last one was completed October 20, 2020. The licensee's 7.01 Medication Management-assessment, Monitoring and Reassessment policy dated September 27, 2022, indicated an annual face to face assessment will be done by the RN and will identify all medications including side effects and contraindications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and	02040		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 26 (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On October 4, 2022, approximately from noon to 2:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A and director of engineering (DOE)-F. On October 4, 2022, at approximately 3:30 pm, a documentation review and interview were performed with the LALD-A and the DOE-F on the hazard vulnerability or safety risk assessment for the memory care physical environment. 1) Review of the plan documentation indicated the licensee had not performed a site-specific	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30823	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02040	Continued From page 27 safety risk assessment on and around the property to identify vulnerabilities to protect the memory care residents from harm. This finding was evident as the documentation provided for survey staff review was tittle, "Timberdale Trance, Vulnerability Assessment, and Individual Abuse Prevention Plan" and did not include site-specific vulnerability content on building and property safety risk assessments. 2) Review of the plan documentation indicated the licensee did not identify mitigations to protect memory care residents from harm. Prevention measures or mitigations must be developed and documented in the plan to address all potential hazard vulnerabilities for this property. On October 4, 2022, at approximately 3:15 p.m., during the exit interview, the LALD-A and the DOE-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=C	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	02110		

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	30823	A. BUILDING: _____ B. WING _____	10/05/2022

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02110	Continued From page 28 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: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. In addition, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client/resident and does	02110		

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02110	Continued From page 29	02110		

not affect health or safety) and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

The facility currently held an Assisted Living with Dementia Care license.

On September 12, 2022, at 10:11 a.m. during the entrance conference, the surveyor asked for the licensee's assisted living with dementia care policies and procedures. The policies and procedures provided did not include the following.
- philosophy of how services are provided;
- evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;
- wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;
- medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;
- staff training specific to dementia care;
- 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 October 5, 2022, at 9:00 a.m. licensed assisted living director (LALD)-A stated "none of the files contained dementia policies, we gave them to everyone, but did not have the

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02110	Continued From page 30 resident/family sign for them or put a copy in their files." The licensee's Resident Record- Information and Content policy dated September 28, 2022, indicated the resident record must include, all records of communications pertinent to the resident's services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:	02170		

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02170	Continued From page 31 (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a comprehensive evaluation for an activity plan with all the required content for three of three residents (R2, R3, R4) who received services under an assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility currently held an Assisted Living with Dementia Care license. R2 R2's diagnoses included dementia.	02170		

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02170	Continued From page 32 R2's undated, Get To Know Me Questionnaire, identified R2's personal history and interests; however, the evaluation did not include the following: - current abilities and skills; - physical abilities and limitations; - adaptations necessary for the resident to participate, and - identification of activities for behavioral interventions. R3 R3's diagnoses included Alzheimer's disease. R3's undated, Get To Know Me Questionnaire, identified R2's personal history and interests; however, the evaluation did not include the following: - emotional and social needs and patterns; - current abilities and skills; - physical abilities and limitations; - adaptations necessary for the resident to participate, and - identification of activities for behavioral interventions. R4 R4's diagnoses included major depressive disorder. R4's undated, Get To Know Me Questionnaire, identified R2's personal history and interests; however, the evaluation did not include the following: - emotional and social needs and patterns; - current abilities and skills; - physical abilities and limitations; - adaptations necessary for the resident to participate, and	02170		

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02170	Continued From page 33 - identification of activities for behavioral interventions. On October 5, 2022, at 10:00 a.m. licensed assisted living director (LALD)-A reviewed the form and regulatory requirement for an activity plan under 144G. 84. LALD-A confirmed they were missing the current physical abilities, limitations, and skills as part of their assessment. The licensee's undated, Activities Assessment policy failed to identify the required content under 144G 84 Subd 4b. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

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

Type: Full
Date: *10/04/22*
Time: 08:00:06
Report: 8044221348

Food and Beverage Establishment Inspection Report

Location:
American Eagle Owatonna
364 Cedardale Drive Se
Owatonna, MN55060
Steele County, 74

Establishment Info:
ID #: 0037467
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074468600
ID #:

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

The following orders were issued during this inspection.

5-200B Plumbing: cross connections

5-203.14I ** Priority 1 **

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

No pressure relief device connected to chemical dispenser installed on mop sink faucet.

Note: A backflow prevention device was added, but is not needed.

Comply By: 10/18/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

SIgn not posted in restroom next to office.

Comply By: 10/11/22

Surface and Equipment Sanitizers

Hot Water: = at 166.8q Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Spray bottle
Violation Issued: No

Type: Full
Date: *10/04/22*
Time: 08:00:06
Report: 8044221348
American Eagle Owatonna

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41.2 Degrees Fahrenheit - Location: Upright 1
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39.9 Degrees Fahrenheit - Location: Corn casserole in upright 1
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40.8 Degrees Fahrenheit - Location: Ham in upright 2
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.0 Degrees Fahrenheit - Location: Upright 2
Violation Issued: No

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

HRD inspection conducted with lead surveyor Tracey Fearon.

Report reviewed on site with director of food service, Brittany.

Establishment Info: bblouin@timbertrace.org

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044221348 of 10/04/22.

Certified Food Protection Manager: Brittany L. Blouin

Certification Number: FM76510 Expires: 03/02/24

Inspection report reviewed with person in charge and emailed.

Signed: Brittany
Inspector signed for Brittany

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