Electronically delivered

July 27, 2022

Administrator
The Preserve Of Roseville
2600 Dale Street North
Roseville, MN 55113

RE: Project Number(s) SL36021015

Dear Administrator:

On July 5, 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 March 24, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the March 24, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on March 24, 2022, found not corrected at the time of the July 5, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on July 5, 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 $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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

authorized in §144G.20.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-517.

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,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36021	A. BUILDING: _____ B. WING _____	R 07/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESERVE OF ROSEVILLE	2600 DALE STREET NORTH ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL36021015-1 On June 27, 2022, through July 5, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on Date, 2022. At the time of the survey, there were 70 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	
{0 660} SS=E	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	{0 660}		

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{0 660}	Continued From page 1 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for four of four employees (unlicensed personnel (ULP)-G, ULP-P, ULP-R, and assisted living director (ALD)-Q) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The Facility TB Risk Assessment dated October 1, 2021, identified the facility was at a medium risk for transmission.	{0 660}		

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{0 660}	Continued From page 2	{0 660}		

ULP-G was hired September 29, 2021, and provided direct cares for residents of the facility. ULP-G's employee record included a (tuberculin skin test) TST dated September 27, 2021, however lacked a second step TST.

ULP-P was hired May 10, 2022, and provided direct cares for residents of the facility. ULP-P's employee record included a chest radiograph (x-ray) dated April 12, 2022, however lacked documentation of a positive TST.

ALD-Q was hired April 25, 2022, and provided on-site supervisory services for the licensee. ALD-Q's employee record included a TB symptom screening form, but lacked documentation of a negative TB test.

ULP-R was hired April 6, 2022, and provided direct cares for residents of the facility. ULP-R's employee record included a TB symptom screening form, but lacked documentation of a negative TB test.

TB testing documentation for ULP-G, ULP-P, ULP-R and ALD-Q was requested June 28, 2022, at 7:55 a.m., and 5:50 p.m., and July 4, 2022, at 1:05 p.m., but was not provided.

The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that

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{0 660}	Continued From page 3 documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated all newly hired staff would receive an Interferon-Gamma Release Assays (IGRA) blood test or a two-step Mantoux (TST) with negative documentation prior to assisting residents. No further information was provided.	{0 660}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of	{0 800}		

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{0 800}	Continued From page 4 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}		
{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 5 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}		
{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 (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: No further action required.	{02040}		

Electronically Delivered

April 25, 2022

Administrator
The Preserve Of Roseville
2600 Dale Street North
Roseville, MN 55113

RE: Project Number(s) SL36021015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 24, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota 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 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $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 Free from Maltreatment reconsideration

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

requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
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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,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING 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: SL36021015 On March 21 through March 24, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were ninety (90) residents with sixty-five (65) residents receiving services under the provider's Assisted Living with Dementia Care license. This resulted in an immediate correction order on March 23, 2022, at 5:17 p.m.; the immediacy was removed on March 24, 2022, the scope and level of noncompliance remains the same.	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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by". Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 21, 2022, at approximately 10:45 a.m., registered nurse (RN)-B stated the licensee's employees in	0 250		

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0 250	Continued From page 3	0 250		

charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services.

The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]:

- I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.

- I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.

- Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.

- Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.

- Reporting of Maltreatment of Vulnerable Adults.

- Electronic Monitoring in Certain Facilities.

- I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone

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0 250	Continued From page 4 conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes	0 250		

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0 250	Continued From page 5 indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by authorized agent (AA)-O on May 25, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that	0 250		

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0 250	Continued From page 6 staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. During interviews on March 22, March 23, and March 24, 2022, RN-B, RN-D, unlicensed personnel (ULP)-G, and staffing coordinator (SC)-M verified the licensee provided the following services: resident assessments, medication and treatment management, staff orientation and training, and delegation of tasks by RNs to ULPs, but failed to implement the corresponding policies and procedures, as required. As a result of this survey, the following orders were issued: 0510, 0580, 0660, 0790, 0800, 0810, 0950, 0970, 1370, 1440, 1470, 1480, 1540, 1620, 1650, 1750, 1760, 1880, 1890, 1940, 1950, 2310, and 2040, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 7 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This had the potential to affect all 90 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: EMPLOYEE EYE PROTECTION On March 22, 2022, at 7:58 a.m., unlicensed personnel (ULP)-F was observed to administer	0 510		

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0 510	Continued From page 8	0 510		

medications to resident (R)-2. ULP-F was observed not wearing eye protection while in R2's room administering medications.

During an interview on March 22, 2022, at 8:20 a.m., ULP-F stated caregivers always wear a mask when in the facility. ULP-F further stated they normally wear eye protection, but forgot to put it on today. ULP-F indicated they should wear eye protection when in resident areas, in resident rooms, and when passing meds.

During an interview on March 22, 2022, at approximately 10:45 a.m., registered nurse (RN)-B stated eye protection should be worn when a caregiver is within six feet of a resident.

The provided COVID-19 and infection control policies did not address the use of eye protection when providing resident cares.

HAND HYGIENE/GLOVES

On March 22, 2022, at approximately 7:33 a.m., during a continuous medication and treatment administration observation, the surveyor made the following observations:
-at 7:33 a.m., ULP-G failed to perform hand hygiene prior to medication administration and failed to don gloves prior to administering an insulin injection of Humolog 7 units (u) for R4.
-at 7:38 a.m., ULP-G failed to perform HH prior to proceeding to R13's room and administering medication to R13.
-at 7:48 a.m., ULP-G failed to perform HH prior to proceeding to R14's room and provide an escort to dining room for R14.
-at 7:59 a.m., ULP-G failed to perform HH prior to proceeding to R15's room and administering medication to R15.

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0 510	Continued From page 9 -at 8:18 a.m., ULP-G failed to perform HH prior to proceeding to R7's room and administering medication to R7. -at 8:25 a.m., ULP-G performed a blood glucose test on R7 without use of gloves. -at 8:26 a.m., ULP-G failed to don gloves prior to administering insulin injections of 35u of Lantus and 10u of insulin lispro for R7. On March 22, 2022, at approximately 8:33 a.m., ULP-G acknowledged they did not perform hand hygiene during medication administration, until they completed medication administration for R7. ULP-G further acknowledged they did not wear gloves when performing blood glucose test and insulin administration. ULP-G stated there were no gloves stocked in resident rooms which is why they did not apply them. On March 22, 2022, at approximately 10:33 a.m., RN-B stated gloves should be worn when insulin is administered. In addition, RN-B stated gloves should be worn when completing a blood glucose test. On March 22, 2022, at 10:44 a.m., RN-B stated hands should be washed before and after taking off gloves, visibly soiled hands, after using the bathroom, caring for anyone with norovirus, and after providing any care to residents. The licensee's Hand Washing policy, dated August 1, 2021, indicated hand washing would be completed before and after caring for someone who is sick, before and after treating a wound, after using toilet, after changing a diaper or cleaning up someone who has used the toilet, after blowing nose, after sneezing or coughing, after handling pet food and after touching garbage.	0 510		

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0 510	Continued From page 10 The licensee's Blood Sugar Testing-Single Equipment Use policy, dated August 1, 2021, indicated staff would wear gloves during blood glucose testing. The licensee's Insulin policy, dated August 1, 2021, lacked information regarding procedure staff should follow when administering insulin. MEDICATION On March 22, 2022, at 7:58 a.m., during a medication administration observation, ULP-F was observed to drop an oral medication on the floor, retrieve the medication from the floor and administer the medication to R2. On March 22, 2022, at 8:05 a.m., ULP-F stated she was taught to administer medications even after they have been dropped on the floor. On March 22, 2022, at 8:40 a.m., ULP-N stated if a medication fell on the floor, they would not administer it, but would place the medication into a "pill pack" and give it to the nurse for disposal. During an interview on March 22, 2022, at 10:46 a.m., RN-D stated if a medication fell on the floor it should be disposed in the appropriate manner. The provided infection control and medication administration policies did not include instructions regarding medications dropped on the floor. Minnesota Department of Health (MDH) COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, indicated health care workers (HCW) with face-to-face contact with residents should wear	0 510		

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0 510	Continued From page 11 medical grade well-fitting facemask and eye protection. MDH guidance titled, Responding to and Monitoring COVID-19 Exposures in Health Care Settings, dated December 8, 2021, indicated to institute universal masking of all health care workers for source control. Universal masking is intended to protect both patients and employees from infected health care workers who may shed virus into the environment before onset of symptoms. Institute use of eye protection (e.g., face shield, goggles) as a way to reduce COVID-19 exposure risk. Eye protection is recommended, at a minimum, for all routine outpatient, acute care, and long-term care encounters when PPE supplies allow. Use of all appropriate PPE can reduce the number of exposures for which exclusion from work is recommended. No further information was provided. TIME PERIOD FOR CORRECTION: 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	0 580		

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0 580	Continued From page 12 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 90 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 the residents). The findings include: On March 21, 2022, at approximately 11:00 a.m., registered nurse (RN)-B stated the licensee had a quality management program and would provide surveyors with information. On March 24, 2022, at approximately 11:55 a.m., the surveyor requested a copy of the quality management meeting minutes from Clinical Care Specialist (CCS)-C, RN-B and RN-E. No quality management meeting minutes were provided throughout the survey. The licensee's Quality Management Project policy, dated August 21, 2022, indicated licensee would maintain at least one documented quality management project and retain records of	0 580		

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0 580	Continued From page 13 project(s) for two years. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for 2 of 3 employees (unlicensed personnel (ULP)-F, ULP-G) with employee records reviewed. This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 14 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The Facility TB Risk Assessment dated October 1, 2021, identified the facility was at a medium risk for transmission. ULP-F was hired December 29, 2021, and provided direct cares for residents of the facility. ULP-F's employee record included a Tuberculin skin test (TST) dated December 27, 2021, however lacked a second step TST. ULP-G was hired September 29, 2021, and provided direct cares for residents of the facility. ULP-G's employee record included a TST dated September 27, 2021, however lacked a second step TST. On March 23, 2022, at 5:05 p.m. staffing coordinator (SC)-M confirmed both ULP-F and ULP-G lacked a second step TST. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the	0 660		

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0 660	Continued From page 15 date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated all newly hired staff would receive a Interferon-Gamma Release Assays (IGRA) blood test or a two-step Mantoux (TST) with negative documentation prior to assisting residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain portable fire extinguishers in accordance with the State	0 790		

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0 790	Continued From page 16 Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect 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 March 23, 2022, between the hours of 10:10 a.m. and 1:20 p.m., survey staff toured the facility with the maintenance director (MD)-K. During the tour, survey staff observed that portable fire extinguishers located throughout the facility were not annually serviced as required. The review of the tags on the extinguishers indicated the last annual service date was consistently dated November 2019. Survey staff explained to MD-K that each portable fire extinguisher was required to be serviced annually by a trained person/vendor to ensure proper operating conditions and recharged. Thereafter, quick monthly inspections of portable fire extinguishers are required by the facility's employees to ensure they are readily available, designated at their installed location, no obvious physical damage or condition to the unit to prevent their operation when needed. MD-K verified the findings during the tour. On March 23, 2022, at approximately 2:50 p.m., MD-K acknowledged the above findings at the exit interview. No further information was provided.	0 790		

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0 790	Continued From page 17 TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, 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, interview, and record review, 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 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). On March 23, 2022, between the hours of 10:10 a.m. and 1:20 p.m., survey staff toured the facility with the maintenance director (MD)-K. At the start of the tour, survey staff collected building construction information from MD-K and received floor plans of the building. The building was opened in 2019 and is a 4-story with an	0 800		

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	36021	A. BUILDING: _____ B. WING _____	03/24/2022

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0 800	Continued From page 18 underground parking garage and fully protected by a fire suppression system. Resident room types for assisted living were studio, one-bedroom, and two-bedroom designs, and for memory care were studio design type. The following findings were observed by survey staff: -The fire-rated door from stair B to the underground parking garage did not latch properly when closed. MD-K explained that it may be from the building settling since the facility was only a couple of years old. -The latch hardware for the fire-rated doors to the trash rooms in the facility were removed and failed to close and latch properly to protect the corridor for building safe exit access. Further investigation, survey staff noticed the hardware were tampered with and asked MD-K about the removal and tampering of the latches on the fire-rated doors. MD-K explained that residents had difficulty opening the doors to drop off trash and therefore, the door hardware were removed for easier resident access to and from the trash rooms. Survey staff explained that the trash rooms are considered hazardous storage rooms and by tampering with the rated-fire doors also comprises the integrity of the building fire safety plan for exit access to protect the residents, staff, and visitors. Survey staff also suggested exploring other code-approved options without tampering with the door hardware on fire-rated doors. - Record review of the facility's Water Temperature Testing Documentation, dated November 29, 2021, indicated readings recorded temperatures for public restroom lavatories (memory care floors) at the outlet of faucets were at 115.3 degrees F, 112.9 degrees F, and 111.3	0 800		

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0 800	Continued From page 19 degrees F, which exceeded the maximum water temperatures allowed by state standards. Water temperatures for lavatories (handwashing sinks) in public restrooms must be limited to a maximum of 110 degrees F or less for safe handwashing temperature by adjusting the dedicated temperature mixing devices serving the public lavatories (See Minn. Rules, part 4714.0407 at https://www.revisor.mn.gov/rules/4714.0407/). On March 23, 2022, at approximately 2:50 p.m., MD-K acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) 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	0 810		

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0 810	Continued From page 20 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 observation, interview, and record review, the licensee failed to provide all required content on the fire safety and evacuation plan, evacuation drills, and the minimum required training of staff on fire safety and evacuation. This has the potential to directly affect the safety of 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 March 23, 2022, between the hours of 10:10 a.m. and 1:20 p.m., survey staff toured the facility with the maintenance director (MD)-K. On March 23, 2022, at approximately 1:30 pm,	0 810		

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0 810	Continued From page 21 survey staff received the facility fire safety and evacuation plan and related documentation for review: FIRE SAFETY AND EVACUATION PLAN -The documentation lacked employee actions to be taken in the event of a fire or similar emergency. -The documentation lacked the specific fire protection procedures necessary for addressing all residents including any unique or unusual resident needs including memory care residents during an evacuation as well as a relocation of the resident plan for a full evacuation. Unique resident-specific needs may include cognitive impairment, wheelchair-bound, on walkers, non-ambulatory, bedridden, and needing assistance during an evacuation. The evacuation plan needs to address partial and total movements and evacuations. -The documentation lacked fire protection procedures for the residents. TRAINING -The training policy lacked the content of employee training on the fire safety and evacuation at least twice per year after the new hire onboard training. Training must be specific to the facility's fire safety and evacuation. -The training policy lacked the content of resident training for residents who are capable of assisting in their own evacuation on proper actions to take during a fire event to include movement, evacuation, or relocation. The training must be available to residents at least once a year. FIRE and EVACUATION DRILLS The drill records showed insufficient number of employee fire safety and emergency drills. Record review indicated one date logged for the	0 810		

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0 810	Continued From page 22 drill, dated July 30, 2022, with no time noted. Drills must also include evacuation drills at least twice per year per shift, with at least one evacuation drill every other month. Fire drills and evacuation drills may be combined when conducting drills. In addition, the lack of drills also violated the facility's policy, Fire Emergency Plan (page 55) which stated that fire drills be performed monthly. On March 23, 2022, at approximately 2:50 p.m., MD-K acknowledged the above findings at the exit interview. Survey staff reminded MD-K that all training and evacuation drills be recorded or documented. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated	0 950		

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0 950	Continued From page 23 Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included designation of representatives in writing with the required statutory language for five of five residents (R3, R2, R4, R6, R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R3, R2, R4, R6, and R7 were admitted under the Comprehensive license: R3 in 2020, and R2, R4, R6, R7 in 2021. The records for these residents included Resident Agreements signed August 1, 2021, October 11, 2021, July 30, 2021, August 1,	0 950		

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0 950	Continued From page 24 2021, and July 30, 2021, respectively. The licensee began providing Assited Living services on August 1, 2021. R3, R2, R4, R6, and R7's Resident Agreements lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On March 23, 2022, at 11:59 a.m. registered nurse (RN)-B verified the right to designate a representative form was not in the resident agreements. Although RN-B stated the forms could be located elsewhere, the requested forms were not provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=F	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	0 970		

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0 970	Continued From page 25 facility's liability for health, safety, or personal property of a resident for five of five residents (R3, R2, R4, R6, R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R3, R2, R4, R6, and R7 were admitted under the Comprehensive license: R3 in 2020, and R2, R4, R6, R7 in 2021. The records for these residents included Resident Agreements signed August 1, 2021, October 11, 2021, July 30, 2021, August 1, 2021, and July 30, 2021, respectively. The licensee began providing Assited Living services on August 1, 2021. R3, R2, R4, R6, and R7's Resident Agreement, page 16, number 33. Indemnification, indicated the resident waived liability (responsibility) of the licensee for damages and liability and expense in connection with loss of life, personal injury or damage to property. On March 23, 2022, at 11:59 a.m. registered nurse (RN)-B acknowledged the indemnification clause was present in the contract given to all residents as of August 1, 2021 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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01370 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 27 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency to include all required content was completed for one of two employees (unlicensed personnel (ULP)-F) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired December 29, 2021, and provided direct cares for residents of the facility. On March 22, 2022, at 7:58 a.m., ULP-F was observed to administer medications to R2. ULP-F's employee record lacked documentation of training for the following topics: -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy;	01370		

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01370	Continued From page 28 - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. On March 23, 2022, at 5:05 p.m. staffing coordinator (SC)-M acknowledged ULP-F's training record did not include the above listed topics. SC-M verified ULP-F's employee record was complete. The licensee's Orientation & Training policy, dated August 1, 2021, indicated training and competency evaluations for all ULPs would include: training on the prevention of falls, communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family, awareness of confidentiality and privacy, understanding appropriate boundaries between staff and residents and the resident's family, and procedures to use in handling various emergency situations. The policy further indicated, in addition to the above training and competencies, training for ULP providing Assisted Living services must include recognizing the physical, emotional, cognitive, and developmental needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 29 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees(unlicensed personnel (ULP)-F and ULP-G) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number	01440		

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01440	Continued From page 30 of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-F and ULP-G were hired December 29, 2021, and September 29, 2021, respectively. Both employee records lacked documentation of direct supervision of RN delegated tasks within 30 days of providing services. On March 23, 2022, at 10:58 a.m. RN-A stated if the 30-day supervision was completed it, would be in the employee record. At 11:47 a.m. RN-E further verified the employee records lacked a 30-day supervision of delegated tasks. RN-E stated the 30-day supervision for ULP-G happened at a time of transition and documentation could be located elsewhere. At the time of the interview the documentation RN-E referenced was requested, but not provided. The licensee's Supervision of Staff - Delegated Services policy dated August 1, 2021, indicated, "Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01470	Continued From page 31	01470		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (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 32 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 employees received orientation to include all required content for two of three employees (unlicensed personnel (ULP)-F and ULP-G) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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-F was hired December 29, 2021, and	01470		

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01470	Continued From page 33 provided direct cares for residents of the facility. ULP-F's employee record lacked documentation the following orientation topics were completed: -An overview of the appropriate Assisted Living statutes 144.G and rules; -Handling of emergencies and use of emergency services; -Compliance with and reporting the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -Consumer advocacy services; -Provider's scope of license and types of assisted living services the employee would provide; and -Review of the principles of person-centered planning and service delivery. ULP-G was hired September 29, 2021, and provided direct cares for residents of the facility. ULP-G's employee record lacked documentation the following orientation topics were completed: -An overview of the appropriate Assisted Living statutes 144.G and rules; -Consumer advocacy services; and -Provider's scope of license and types of assisted living services the employee will provide. On March 23, 2022, at 5:05 p.m. Staffing Coordinator (SC)-M acknowledged ULP-F and ULP-G lacked documentation on topics listed above. In addition, SC-M stated, "To be honest, I didn't even get the training when I was hired. I just received my training in the last week on those important issues. They told me when I came in to	01470		

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01470	Continued From page 34 just flip to the back and sign the back pages." The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated, "All staff of [licensee] providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents." The policy further detailed the orientation must include: -An overview of the appropriate Assisted Living statutes and rules -An introduction and review of the facilities' 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 the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) -The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services	01470		

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01470	Continued From page 35 -A review of the types of assisted living services the employee would be providing and the facility's category of licensure -The staff person's job description upon hire and whenever there was a change of the job description that changed the nature of the job or how the job was to be performed -The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services -The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment was prohibited. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01480 SS=D	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing assisted living services were oriented to each individual resident and the services to be provided for one of three employees (unlicensed personnel (ULP)-H) with employee records	01480		

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01480	Continued From page 36 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-H was hired on March 21, 2022, through the licensee's contract agency. On March 22, 2022, at 7:50 a.m. the following was observed: -ULP-G asked ULP-H to assist with a two-person transfer and for assistance with answering call lights. -ULP-H stated they did not know how to find which residents had activated call lights. -ULP-G asked to see ULP-H's portable electronic device (used for documentation of cares, medication administration, and call light notification) to instruct ULP-H on call lights. -ULP-H was observed to not be carrying a portable electronic device. On March 22, 2022, at 7:53 a.m. ULP-H stated they were not oriented to the residents they were currently caring for. In addition, ULP-G stated they had not received orientation to the facility or the documentation system including the portable electronic device. On March 22, 2022, at 11:11 a.m. registered nurse (RN)-B stated if a ULP was from a contract	01480		

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01480	Continued From page 37 agency they were trained when they arrive at the facility. In addition, RN-B stated a ULP would sign an acknowledgement they had read the resident service plans each shift. On March 22, 2022, at approximately 11:11 a.m. the surveyor requested documentation of orientation for ULP-H. On March 24, 2022, at approximately 10:25 a.m. the surveyor again requested documentation of orientation for ULP-H. The surveyor was provided a training form signed by ULP-H and dated the same day, March 24, 2022. The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated staff providing assisted living services would be oriented to each individual and the services they would provide in person, orally, written or electronically. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01480		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	01540		

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01540	Continued From page 38	01540		

dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for two of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-F), with employee records reviewed.

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

The findings include:

The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective August 1, 2021.

RN-A
RN-A was hired January 3, 2022, and provided supervision and direct care services for residents of the facility. RN-A's training and orientation records indicated 5.25 hours of dementia care

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01540	Continued From page 39 training was completed February 7, through February 13, 2022. On March 23, 2022, at 1:10 p.m. RN-B stated the documentation of dementia care education in RN-A's record was all that was currently available. ULP-F ULP-F was hired December 29, 2021, and provided direct care services for residents of the facility. ULP-F's training and orientation records indicated 3.0 hours of dementia care training was completed February 12, through March 4, 2022. On March 23, 2022, at 5:05 p.m. staffing coordinator (SC)-M verified ULP-F's employee record lacked documentation of 8 hours of dementia care education. SC-M stated no further dementia care documentation was available for ULP-F. The licensee's Dementia Training policy dated August 1, 2021, indicated supervisors of direct care staff would complete eight (8) hours of initial training within 120 hours of the employment start date, and direct care employees would complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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01620	Continued From page 40	01620		

be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an ongoing resident reassessment that did not exceed 90 days as required for one of five 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

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01620	Continued From page 41 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6 was admitted in 2021 under the Comprehensive home care license and began receiving assisted living services on August 1, 2021. R6's Service Plan dated June 29, 2021, indicated R6 received assistance with bathing, grooming and hygiene, dressing, mobility, medication administration, and toileting. R6's record indicated the RN completed a 14-day assessment on July 12, 2021, a 90-day review on October 12, 2021 (92 days after the previous assessment), and February 1, 2022 (112 days after the previous assessment). On March 22, 2022, at approximately 12:23 p.m. RN-D confirmed R6's assessments exceeded 90 days and confirmed there were no other assessments completed for R6. RN-D stated assessment may have been late due to R6 moving from independent living to assisted living. The licensee's Assessment, Reviews & Monitoring policy dated August 1, 2021, indicated ongoing resident reassessment and monitoring would be conducted as needed based on changes in the needs of the resident and could not exceed 90 calendar days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

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01650	Continued From page 42	01650		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for five of five residents (R3, R2, R4, R6, R7) with records reviewed.	01650		

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01650	Continued From page 43 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: R3 was admitted in 2020 under the Comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's service plan dated June 23, 2021, indicated R3 received services to include assistance with medications, activities, bathing, grooming, dressing, eating, toileting and mobility. R2 was admitted in 2021 under the Comprehensive home care license and began receiving assisted living services on August 1, 2021. The service plan in R2's record was undated, and indicated R2 received services to include assistance with medications, activities, bathing, grooming, dressing, eating, toileting and mobility. R4 was admitted in 2021 under the Comprehensive home care license and began receiving assisted living services on August 1, 2021. R4's service plan dated July 20, 2021, indicated R4 received services for bathing, grooming, hygiene, dressing, medication administration, and toileting. R6 was admitted in 2021 under the Comprehensive home care license and began receiving assisted living services on August 1, 2021. R6's service plan dated June 29, 2021,	01650		

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01650	Continued From page 44 indicated R6 received assistance with bathing, grooming and hygiene, dressing, mobility, medication administration, and toileting. R7 was admitted in 2021 under the Comprehensive home care license and began receiving assisted living services on August 1, 2021. R7's service plan dated June 7, 2021, indicated R7 received services for activities, transportation, bathing, dressing, grooming and hygiene, meals, blood glucose monitoring, medication administration, and mobility. R3, R2, R4, R6 and R7's service plans lacked the method of staff supervision. On March 24, 2022, at 10:46 a.m. clinical care specialist (CCS)-C verified the resident service plans lacked the method of staff supervision. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include, "A schedule and method for the next planned monitoring of staff providing services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated	01750		

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01750	Continued From page 45 the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident and were able to demonstrate the ability to competently follow the procedure to perform the tasks for one of two employees (ULP-G) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G was hired on September 29, 2021, to provide direct care services to residents. On March 22, 2022, at approximately 7:33 a.m. and 8:25 a.m. during observation, ULP-G did not prime the insulin pen, wear gloves, or clean the injection site prior to insulin administration with R4 and R7. At 8:33 a.m. ULP-G verified she did not use gloves or alcohol wipe prior to	01750		

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01750	Continued From page 46 administration of insulin due to lack of supplies in room. ULP-G stated she was not trained to prime insulin pens prior to insulin administration. ULP-G further stated the licensee offered a medication delegation class. ULP-G stated she had not attended this class. On March 22, 2022, at 10:33 a.m. registered nurse (RN)-B stated all ULP staff attended a medication delegation class for administering insulin where they would complete a competency; thirty (30) days from competency the RN would do a 30-day supervision. ULP-G's employee record lacked both the insulin administration competency and a 30-day supervision. The licensee's Insulin policy dated August 1, 2021, lacked specific language for administration of insulin with a pen. The licensee's Orientation & Training policy dated August 1, 2021, indicated ULP's who were determined to be competent and possessed the knowledge and skills consistent with the complexity of task, would be permitted to perform the delegated task. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760		

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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 per manufacturers recommendations for two of four residents (R4, R7) and failed to ensure prescriber orders were transcribed as ordered for one of four residents (R8) observed for medication administration.

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

The findings include:

PROCESS OF MEDICATION ADMINISTRATION
R4
R4 had diagnoses to include diabetes and vascular dementia without behavioral

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disturbance. R4's service plan dated July 20, 2021, indicated R4 received services for bathing, grooming, hygiene, dressing, medication administration, and toileting.

R4's medication administration record (MAR) dated March 2022 included: Lantus 23 units (U) in the am, Lantus 30 U in the evening, Trulicity 0.75 milligrams (mg) on Tuesdays, Trulicity 1.5 mg on Thursdays, blood glucose monitoring, and Humalog 7 U three times per day.

On March 22, 2022, at approximately 7:33 a.m. during a medication administration observation, unlicensed personnel (ULP)-G verified with the electronic medication administration record (EMAR) that R4 would receive 7 U of Humalog. ULP-G prepared the Humalog insulin pen (a multiple dose pen-shaped injector device used for insulin administration) by placing the needle on the end of the insulin pen and immediately dialed the pen to 7 U. R4 raised shirt to expose abdomen. ULP-G proceeded to administer the medication. ULP-G failed to prime the insulin pen and clean injection site prior to injecting the prescribed 7 U of Humalog to R4.

R7
R7 had diagnoses to include Alzheimer's disease and long-term use of insulin. R7's service plan dated June 7, 2021, indicated R7 received services for activities, transportation, bathing, dressing, grooming and hygiene, meals, blood glucose monitoring, medication administration, and mobility.

R7's MAR dated March 2022 included Lantus 35 U one time per day, insulin Lispro 10 U before meals per day, and blood glucose monitoring four times per day.

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01760	Continued From page 49 On March 22, 2022, at approximately 8:25 a.m. during a medication administration observation, ULP-G was observed to perform a blood glucose test on R7 which resulted in a reading of 195 milligrams (mg)/deciliter (dL). ULP-G confirmed with the EMAR that R7 should be administered 35 U of Lantus and 10 U of insulin Lispro. ULP-G prepared the Lantus pen and insulin Lispro pen by placing the needle on the ends of the insulin pens and immediately dialed the Lantus pen to 35 U and the insulin Lispro pen to 10 U. R7 raised shirt to expose abdomen. ULP-G proceeded to administer both medications. ULP-G failed to prime the insulin pen and clean injection site prior to injecting prescribed 35 U of Lantus and 10 U of insulin Lispro to R7. On March 22, 2022, at 8:33 a.m. ULP-G verified they did not use an alcohol wipe to clean the resident's skin prior to administration of insulin. In addition, ULP-G stated they were not trained to prime insulin pens prior to administration. On March 22, 2022, at 10:33 a.m. registered nurse (RN)-B stated staff were trained to prime insulin pens by dialing up 2 U and then wasting the insulin prior to dialing the prescribed dosage of insulin. In addition, RN-B verified staff were educated to wipe the injection site with an alcohol wipe prior to injecting insulin. The manufacturer's instructions for the use of insulin Lispro KwikPen dated 2020, indicated the insulin pen should be primed with two units prior to dialing the prescribed dosage and, if not completed before each injection, too much or too little insulin may be administered. The manufacturer's instructions for the use of	01760		

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01760	Continued From page 50 insulin Humalog KwikPen dated February 2019, indicated the insulin pen should be primed with two units prior to dialing the prescribed dosage. The manufacturer's instructions for the use of Lantus Solostar dated 2019, indicated the insulin pen should be primed with two units prior to dialing the prescribed dosage. The licensee's Insulin policy dated August 1, 2021, lacked specific language for insulin administration with an insulin pen TRANSCRIPTION OF PRESCRIBER'S ORDERS R13 was admitted in 2021 under the Comprehensive home care licnese with diagnoses to include chronic pain, hypertension, and edema. R13's prescriber orders dated September 23, 2021, included vitamin D3 1000 international unit (IU) once daily, furosemide 40 milligrams (mg) once daily, aspirin 81 mg one time per day, and diltiazem extended release 120 mg once daily. On March 22, 2022, at 7:38 a.m. during a medication administration observation, ULP-G prepared R13's medications by reviewing medication labels as they were removed from pharmacy bubble packs. R13's Vitamin D3 medication label directed to give Vitamin D3 1,000 IU one time per day. R13's EMAR indicated to administer Vitamin D3 one tablet, one time per day, but lacked the dosage. After administration, ULP-G stated it was the correct dose, but it was transcribed incorrectly on the EMAR. On March 22, 2022, at 10:50 a.m. RN-B stated the EMAR should match the provider order and medication from the pharmacy. In addition, RN-B	01760		

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01760	Continued From page 51 stated the EMAR should have the medication name, time, pharmacy, communication method, dose, route of administration, scheduling details, special instruction and diagnosis. The licensee's Medication & Treatment Orders policy dated August 1, 2021, indicated the nurse would assure prescriber orders for medications were kept on file in the resident record and must include the name of the resident, a description of the medication, frequency, duration, and other information needed to carry out the order. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store all prescription medications according to the manufacturers' directions. This had the potential to affect all eight (8) residents receiving refrigerated medications. 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	01880		

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01880	Continued From page 52 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 March 22, 2022, at 9:34 a.m. the surveyor observed the medication storage regriferator. The thermometer inside the medication refrigerator was observed to indicate 48 degrees Fahrenheit (°F). The medication refrigerator contained the following prescribed medications: -Novolin R vials and pens (a short-acting insulin); -Lantus Solostar pens (a long-acting insulin); -Humalog and Lispro injection pens (a short to intermediate-acting insulin); -Trulicity (an injection used to treat diabetes); -Latanoprost (an eye drop used to treat glaucoma); -Brimonidine Tartrate (an eye drop used to treat glaucoma); and -Dorzolamide HCL and Timolol Maleate (an eye drop used to treat glaucoma). The packaging for Brimonidine Tartrate Ophthalmic Solution 0.2% eye drops and Dorzolamide HCL and Timolol Maleate eye drops were both observed to indicate they should be stored at 20-25 degrees Celsius (°C) (68-77 °F), or room temperature. The refrigerator temperature log for March 1 through 20 2022, indicated temperatures ranging from 48 to 52°F. The Novolin R manufacturer safety data sheet, dated December 2, 2020, indicated a storage temperature of 2 degrees Celsius (°C) to 8°C (36°F to 46°F) for a maximum period of 24 months.	01880		

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01880	Continued From page 53 The Lantus Solostar manufacturer storage information, revised December 2020, indicated the medication is good until the expiration date if stored refrigerated (36°F to 46°F), or for 28 days if stored at room temperature (below 86°F). The Humalog manufacturer instructions for use, revised April 2020, indicated, "Store unused Pens in the refrigerator at 36°F to 46°F (2°C to 8°C). Do not freeze your insulin. Do not use if it has been frozen." The Trulicity manufacturer storage and disposal information dated January 2022, indicated, "Store your pen in the refrigerator, but do NOT freeze your pen." The Latanoprost storage information from the Food and Drug Administration (FDA) and the National Institutes of Health (NIH), revised November 2010, indicated, "Store unopened bottle(s) under refrigeration at 2°C to 8°C (36°F to 46°F)." On March 22, 2022, at approximately 9:40 a.m. surveyor and registered nurse (RN)-D observed and verified the thermometer in the refrigerator indicated 50°F. RN-D further verified insulins should be stored at 36-46°F. The licensee's Medication storage policy dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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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 including the opened date for time sensitive medication storage for two of five residents (R2, R7) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 On March 22, 2022, at 8:17 a.m., the surveyor observed R2's in-room medication storage. R2's Refresh tears eye drops were open and lacked a label to indicate the date staff first used the eye drops and when the eye drops would expire. Undated manufacturer instructions indicated Refresh tears should be discarded 90 days after opening.	01890		

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01890	Continued From page 55 On March 22, 2022, at 1:28 p.m. registered nurse (RN)-B verified the Refresh tears eye drops in R2's medication drawer were not labeled with the date opened. RN-B indicated the eye drops should be dated when opened. R7 On March 22,2022, at approximately 8:18 a.m. the surveyor observed R7's Lantus Solostar pen and two (2) insulin Lispro injection KwikPens opened without labels to indicate the date staff first used the insulins and when the insulins would expire. The manufacturer's instructions for the use of the Lantus Solostar pen dated 2019, directed for the insulin to be discarded 28 days after being opened. The manufacturer's instructions for the use of the insulin Lispro injection KwikPen dated June 2020, directed for the insulin to be discarded 28 days after being opened. On March 22, 2022, at approximately 8:30 a.m. ULP-G confirmed insulins were opened and lacked identification of the date opened and expiration date. ULP-G stated the staff who opened the insulin, should have label/dated it. On March 2, 2022, at approximately 11:02 a.m. RN-B and RN-D stated insulin should be dated once opened and discarded in 28 days or when the manufacturer recommends. The licensee's Medication storage policy dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations.	01890		

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01890	Continued From page 56 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

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01940	Continued From page 57 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual treatment management plan to include all required content for two of four residents (R3, R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3 was admitted in 2020 under the Comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's diagnoses included congestive heart failure and dementia. On March 22, 2022, at 8:36 a.m., the surveyor observed R3 sitting in a wheelchair in the dining room wearing compression stockings. On March 22, 2022, at 8:37 a.m. unlicensed personnel (ULP)-I verified R3 had compression stockings in place and wore compression stockings daily. ULP-I indicated staff assisted R3 to apply compression stockings in the morning, and assists R3 to remove compression stockings	01940		

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01940	Continued From page 58 at night. R3's service plan dated June 23, 2021, lacked information regarding the use of compression stockings. R3's medical record included a signed provider order dated September 9, 2021, which indicated, "Compression stockings 15-20mmHg --- on for 12 hours during the day and off for 12 hours at night. Nursing please measure from floor to ankle and floor to knee bilaterally and include with the order to the pharmacy. Please have the aides assist in placing daily." R3's caregiver service documentation for March 2022, indicated staff assisted R3 with the use of compression stockings daily from March 1 through March 21, 2022. R3's record lacked a treatment or therapy management plan to include information regarding the use of compression stockings. On March 22, 2022, at 1:18 p.m. registered nurse (RN)-D verified the use of compression stockings was not indicated in R3's treatment or therapy management plan and further verified the information regarding the use of compression stockings was not present in R3's service plan. R7 R7 was admitted in 2021 under the Comprehensive home care license and began receiving assisted living services on August 1, 2021. R7's diagnoses included dementia without behavior, Alzheimer's disease, hypertension, anxiety disorder, and long-term use of insulin. R7's service plan dated June 7, 2021, indicated	01940		

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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
01940	Continued From page 59 R7 received services for activities, transportation, bathing, dressing, grooming and hygiene, meals, blood glucose monitoring, medication administration, and mobility. R7's individual treatment management plan lacked the following content: - documentation of specific resident instructions relating to the treatments or therapy administration; and - procedure for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arose with treatments or therapy services. R7's MAR dated March 2022 included insulin glargine 35 units (U) one time per day, insulin lispro 10 U before meals per day, and blood glucose monitoring four times per day. On March 22, 2022, at approximately 8:25 a.m., the surveyor observed ULP-G perform a blood glucose test on R7. R7's blood glucose was 195 milligrams (mg)/deciliter (dL). At approximately 8:26a.m. ULP-G administered 35 U of Lantus and 10 U of insulin lispro to R7. At approximately 8:33 a.m. ULP-G verified orders for R7 did not indicate when to call a nurse if blood sugars where abnormal and when to hold insulins. On March 22, 2022, at approximately 10:40 a.m. RN-B stated blood sugar orders and insulin orders would have parameters under special instruction tab in PointClickCare. In addition, RN-B stated in a delegation class that staff attended, the staff would learn to contact someone if blood sugar was under 70 or above 200. The licensee's Treatment & Therapy	01940		

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01940	Continued From page 60 Management Plan policy dated August 1, 2021, indicated, "[licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	01950		

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01950	Continued From page 61 or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure, prior to delegating nursing tasks, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and failed to ensure the ULP demonstrated the ability to competently follow the procedure to perform the tasks for one of two employees (ULP-G) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G was hired on September 29, 2021, to	01950		

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01950	Continued From page 62 provide direct care services to residents. R7's service plan dated June 7, 2021, indicated R7 received services for activities, transportation, bathing, dressing, grooming and hygiene, meals, blood glucose monitoring, medication administration, and mobility. R7's medical administration record (MAR) dated March 2022 included blood glucose monitoring four times per day. On March 22, 2022, at approximately 8:25 a.m., the surveyor observed ULP-G confirm with electronic medical record (EMAR) to perform a blood glucose test. ULP-G explained to resident that they were going to perform a blood glucose test. ULP-G prepared blood glucose test strip. ULP-G twisted off cap of lancet, placed lancet on index finger and pressed down puncturing R7's finger. ULP-G then attempted to press on finger to obtain blood specimen however, asked R7 to press on finger to obtain a larger sample. ULP-G collected blood on test strip which resulted in a reading of 195 milligrams (mg)/deciliter (dL). ULP-G disposed of the used lancet in a sharps container and documented results in the EMAR. ULP-G failed to perform hand hygiene, wear gloves, wipe puncture site off with alcohol wipe, and apply pressure to resident finger with cotton ball after puncture. ULP-G's employee record lacked a competency for blood glucose testing. On March 22, 2022, at 8:33 a.m. ULP-G stated they had not been trained on blood glucose testing. In addition, ULP-G stated the licensee offered a medication delegation class, however ULP-G had not attended.	01950		

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01950	Continued From page 63 On March 22, 2022, at 10:40 a.m. RN-B stated ULPs attend a class where they learn about blood glucose testing and were given a competency. In addition, RN-A stated, when performing blood glucose checks, staff should check the EMAR, gather supplies, put on gloves, use alcohol wipe to clean finger, and obtain blood sample. The licensee's Blood Sugar Testing-Single Equipment Use policy dated August 1, 2021, indicated when performing a blood glucose test staff would perform hand hygiene, wear gloves, clean puncture site with alcohol, puncture finger with lancet, apply blood on the test strip, obtain test results, place lancet sharps container, apply pressure to finger with cotton ball, remove gloves and document results. The licensee's Orientation & Training policy dated August 1, 2021, indicated ULPs who were determined to be competent and possess the knowledge and skills consistent with the complexity of task would be permitted to perform the delegated task. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
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	02040		

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02040	Continued From page 64 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 (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, interview and record review, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify both the hazard vulnerabilities and the mitigations on and around the property. The hazards identified in the HVA plan must be mitigated to protect the residents from harm. This has the potential to directly affect all memory care residents receiving assisted living services and staff. 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 March 23, 2022, from approximately 10:10 a.m. to 1:20 p.m., survey staff toured the facility with the maintenance director (MD)-K. At the start of the tour, survey staff collected building construction information from MD-K and received floor plans of the building. The building is a 4-story with an underground parking garage and	02040		

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02040	Continued From page 65 fully protected by a fire suppression system. Memory care unit was secured and located on the first and second floor wings of the facility, and all resident rooms were studio-type (efficiency) design. On March 23, 2022, at approximately 1:30 pm, survey staff received the HVA documentation, Kaiser Permanente, Appendix B (undated), for review: -The HVA plan documentation lacked specific hazard assessment content on the interior assessment of the property to protect the memory care residents from harm. Hazard assessments on the HVA plan must also include specific safety risks or potential hazard vulnerabilities such as resident elopement as a potential hazard throughout and around the memory care building including deactivation of power doors due to loss of power or fire alarm activation, the risks of the resident room windows being compromised (windows throughout were the break-away designed to be removable for cleaning), potential risks of the accessing hot food wells, stovetop, oven, and toasters in the dining areas, potential risks of being out on the deck on the second floor without supervision, and the risks of the misuse of portable fire extinguishers and/or architectural accessories throughout the building that may harm a memory care resident. - The facility HVA plan lacked mitigations documentation including safety measures and/or training provided to the hazard vulnerability and safety risk assessment identified on the facility's interior and around the exterior of the property to protect all memory care residents from potential harm.	02040		

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02040	Continued From page 66 On March 23, 2022, at approximately 2:50 p.m., MD-K acknowledged the above findings at the exit interview. Survey staff explained that all potential safety risks or harm must be assessed, documented, and be provided with mitigations to protect memory care residents from harm. Staff also suggested MD-K or designated safety officer perform a walk-through of their memory care unit for a more comprehensive list of hazard assessments to establish mitigations to protect the memory residents from harm that includes elopement risks. Special consideration needs to be given to mitigate the windows in the memory care units since the windows are the breakaway type and can be opened even after the window stoppers were installed as mitigation to prevent resident elopement. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	02040		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards with bed rails for three of three residents (R6, R2, R3) with records reviewed. This resulted in an	02310		

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02310	Continued From page 67	02310		

immediate correction order on March 23, 2022, at 5:17 p.m.
In addition, the licensee failed to implement reasonable fall interventions and provide reassessment upon change of condition related to falls for one of five residents (R2) with records reviewed.

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

The findings include:

BED RAILS
R6
R6 was admitted June 29, 2021, and had diagnoses to include heart failure and anxiety.

R6's record included a bed rail assessment dated June 29, 2021, indicating R6 did not use bed rails.

R6's most recent Side Rail Risk assessment form dated February 1, 2022, did not indicate R6 used bed rails.

On March 22, 2022, at 9:32 a.m. during an observation of R6's room, the bed was observed to have a partial side rail in place. The side rail was observed to be a portable, unattached bed rail, that lacked a safety retention strap. The rail was observed to be shifted from it's standard position, approximately 10 inches away from the

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02310	Continued From page 68 mattress. On March 23, 2022, at 2:10 p.m. mintenance director (MD)-K verified dimensional measurements had not been assessed or documented for bed rails in the facility prior to the survey. At 3:40 p.m. MD-K was observed measuring R6's portable bedrail, which did not comply with FDA requirements. The dimensional measurement of zone 1 was 16 inches, zone 2 was 18 inches, and zone 3 was 1 inch. The space in zone 6 between the side rail and the headboard was 2.5 inches. The bedrail was noted not to be secure. MD-K verified the siderail did not include a safety retention strap. R2 R2 was admitted October 11, 2021, and had diagnoses to include Parkinson's disease. R2's Service Plan Agreement dated October 11, 2021, indicated R2 used half bed rails on the upper half of the bed for mobility. A subsequent service plan, undated, indicated R2 used a full bed rail on the left side of the bed (near the wall) for mobility. R2's record included a form titled "MN JSL Comprehensive - V2" dated February 3, 2022, that indicated bed rail use was from family request, to include a full bed rail on the left side for enhanced bed mobility. The record lacked documented evidence the side rail dimensional measurements were included in the assessment, to ensure compliance with Food and Drug Administration (FDA) guidelines, and lacked a risk versus benefit acknowledgement based on the assessed risk. On March 22, 2022, at 7:29 a.m. during an	02310		

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02310	Continued From page 69 interview with R2, the bed was observed to have a full rail in place on the left side, against the wall. On March 23, 2022, at 3:50 p.m. maintenance director (MD)-K was observed measuring R2's bedrail, which was found to be within the FDA recommended dimensional measurements. Dimensional measurements of zones 1-3 of the bedrail were between 2.5 inches to 4.5 inches. There was no space noted between the mattress and the side rail on the side of the bed. The space in zone 6 between the side rail and the headboard was 2.5 inches. The bedrails were noted to be secure. MD-K stated the rails were FDA compliant as they were original manufacturer parts of the bed. R3 R3 was admitted November 30, 2020, and had diagnoses to include congestive heart failure and dementia. R3's service plan, dated June 23, 2021, indicated R3 used a quarter side rail on the left side of the bed and a half side rail on the right side of the bed for bed mobility and transfers. R3's record included a bed rail assessment dated June 23, 2021, that indicated bed rail use and included a risk versus benefit acknowledgement. The record lacked documented evidence the side rail dimensional measurements were included in the assessment to ensure compliance with Food and Drug Administration (FDA) guidelines. On March 22, 2022, at 9:19 a.m. during an observation of R3's room, the bed was observed to have partial side rails in place on both sides of the bed.	02310		

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02310	Continued From page 70 On March 23, 2022, at 3:30 p.m. MD-K was observed measuring R3's bedrails, which were found to be within the FDA recommended dimensional measurements. Dimensional measurements of zones 1-3 of the bedrail were between 1.75 inches to 2.5 inches. There was a space less than 0.5 inches noted between the mattress and the side rails on both sides of the bed. The space in zone 6 between the side rails and the headboard was 3 inches. The bedrails were noted to be secure. MD-K stated the rails were FDA compliant as they were original manufacturer parts of the bed. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's siderails policy dated August 1, 2021, indicated, "When [licensee] is aware a home care resident is utilizing side rails (a medical device) on a bed, [licensee] will assess the use, educate the resident, and when	02310		

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02310	Continued From page 71 appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail." The policy further indicated, "1. Staff from [licensee] will determine if the side rail is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below: a. The side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. c. The side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1, 2, and 3 must not exceed 4.75". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On March 24, 2022, the immediacy was removed, scope and level of noncompliance remains the same. FALLS-INTERVENTIONS R2 was admitted October 11, 2021, and had diagnoses to include Parkinson's disease. R2's Service Plan Agreement dated October 11, 2021, identified R2 will not sustain any injuries related to falls, and included the following interventions initiated October 10, 2021, upon admission:	02310		

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02310	Continued From page 72 -Ensure that walk ways are free of clutter -Remind to call for assistance During an interview on March 24, 2022, clinical care specialist (CCS)-C verified R2's current service plan was not dated, and stated the current service plan was last updated February 15, 2022. R2's current Service Plan Agreement, updated February 15, 2022, identified R2 will not sustain any injuries related to falls, and included the following interventions (undated): -Encourage resident to stay in common areas as much as possible. -Encourage use of walker basket -Ensure grip socks at all times -Ensure that walk ways are free of clutter. -Visual reminders in room and bathroom to call for assistance. R2's medical record indicated 9 falls occurred since admission, on the following dates: October 14 and 19, 2021, November 2, 11, 14, and 27, 2021, December 13, 2021, February 15, 2022, and March 16, 2022. R2's record included nursing progress notes which indicated the following new interventions implemented in response to falls identified on the following dates: November 11, 2021 - "Resident to wear gripper socks at all times" November 14, 2021 - "Will place visual reminders in room to call for help before getting up" November 27, 2021 - "Encourage resident to stay in common areas as much as possible" December 13, 2021 - "Encourage use of walker basket"	02310		

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	36021	A. BUILDING: _____ B. WING _____	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESERVE OF ROSEVILLE	2600 DALE STREET NORTH ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 73 R2's record included an incident report dated October 14, 2021, indicating R2 had a witnessed fall. The report identified the intervention, "Request for PT/OT referral". R2's record included an incident report dated October 19, 2021, indicating R2 had an un-witnessed fall. The report identified the intervention, "Fall alarm in place when resident is not supervised". R2's record included an incident report dated November 2, 2021, indicating R2 had an un-witnessed fall. The report identified the intervention, "Ensure resident bed alarm is functioning at the start of each shift". R2's record included an incident report dated February 15, 2022, indicating R2 had an un-witnessed fall. The report did not indicate a new intervention. R2's record included an incident report dated March 16, 2022, indicating R2 had an un-witnessed fall. The report did not indicate a new intervention. R2's Service Plan Agreement lacked documentation of any new fall intervention implemented in response to falls occurring on February 15, 2022, and March 16, 2022. R2's record included a nursing progress note, dated November 19, 2021, indicating, "Family request that resident [sic] able to be independent in transfers and ambulation despite risk of falls. Family also ok with no longer having fall alarm in place at this time." On March 23, 2022, at 1:16 p.m., R2's room was	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36021	A. BUILDING: _____ B. WING _____	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESERVE OF ROSEVILLE	2600 DALE STREET NORTH ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 74	02310		

observed to lack visual reminders instructing R2 to call for help for transferring as indicated in R2's current service plan.

During an interview on March 23, 2022, at 12:47 p.m., registered nurse (RN)-E stated new interventions should be implemented after each fall.

On March 24, 2022, at approximately 11:00 a.m., CCS-C verified R2's current signed service plan included the fall intervention, "Visual reminders in room and bathroom to call for assistance". CCS-C further verified no signage was present in R2's room reminding R2 to call for assistance. CCS-C indicated fall alarms and visual reminders had not been effective interventions and were discontinued.

FALLS-ASSESSMENTS
R2's record included an initial comprehensive nursing assessment, dated October 11, 2021, a 14-day assessment dated October 24, 2021, and change of condition assessments completed November 19, 2021, and February 3, 2022.

R2's change of condition assessment dated November 19, 2021, indicated the reason for the assessment as, "COC-return from hospital".

R2's record lacked nursing change of condition assessments related to falls occurring October 14 and 19, 2021, November 2, 11, 14, and 27, 2021, December 13, 2021, February 15, 2022, and March 16, 2022.

R2's record included a MN JSL Fall Risk Assessment, dated October 11, 2021, completed upon admission. R2's record included subsequent Fall Risk Asessments dated, October

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36021	A. BUILDING: _____ B. WING _____	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESERVE OF ROSEVILLE	2600 DALE STREET NORTH ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 75 28, 2021, November 19, 2021, December 2, 2021, and February 3, 2022. During an interview on March 23, 2022, at 12:47 p.m., RN-E stated regarding falls, they would assess the resident per the licensee's policy. On March 24, 2022, at 10:46 a.m., CCS-C verified all assessments had been provided to surveyor for R2. CCS-C stated they would not consider a fall to be a change of condition and would not automatically perform a change of condition assessment after each fall. The American Nurses Association (ANA) defines standards for registered nurses. In an article posted by National Library of Medicine, last updated on October 23, 2021 titled, Nursing Professional Development Standards, indicated the standards of practice include documentation of desired outcomes and establishing a plan to achieve the desired outcomes. The Minnesota Nurse Practice Act in 148.171 Subd. 15 defines, "The 'practice of professional nursing' as the performance... of those services that incorporates caring for all patients in all settings through nursing standards recognized by the board and includes, but is not limited to:...developing nursing interventions to be integrated with the plan of care...". The licensee's Assessment, Reviews & Monitoring policy, dated August 1, 2021, indicated, "Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident". The licensee's Resident Change in Condition or Need policy, dated August 1, 2021, indicated,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36021	A. BUILDING: _____ B. WING _____	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESERVE OF ROSEVILLE	2600 DALE STREET NORTH ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 76 "when changes in condition or need are identified, a Registered Nurse or other licensed health professional will initiate a change in condition assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *03/22/22*
Time: 08:25:13
Report: 1018221039

Food and Beverage Establishment Inspection Report

Location:
The Preserve Of Roseville
2600 Dale Street North
Roseville, MN55113
Ramsey County, 62

Establishment Info:
ID #: 0039254
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122020708
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.

3-500C Microbial Control: date marking

3-501.17A ** Priority 2 **

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

HARD BOILED EGGS IN THE MEMORY CARE SERVICE KITCHEN COOLER OBSERVED WITHOUT DATE MARK. EGGS WERE DISCARDED BY KITCHEN MANAGER DURING THE INSPECTION.

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Hot Water: = at 166 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Hot Water: = at 161 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ EGGS
Temperature: 37 Degrees Fahrenheit - Location: SERVICE KITCHEN COOLER
Violation Issued: No

Process/Item: Cold Holding/ BUTTER
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ SAUSAGE
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHEESE
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ TOMATO
Temperature: 38 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ HAM
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding/ HAM SALAD
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding/ SOUP
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

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

VIEWED ILLNESS LOG AND DISCUSSED ILLNESS POLICY.

VIEWED COOKING TEMPERATURE LOGS.

OBSERVED PROPER COOLING AND THAWING.

Type: Full
Date: *03/22/22*
Time: 08:25:13
Report: 1018221039
The Preserve Of Roseville

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1018221039 of 03/22/22.

Certified Food Protection Manager: KEITH DEWAYNE SIMMONS

Certification Number: FM72977 Expires: 08/27/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
KEITH SIMMONS
KITCHEN MANAGER

Signed: _____
Inspector Number 1018

6512014500