Electronically Delivered

March 7, 2024

Licensee
Serenity Place on 7th
329 7th Avenue Southeast
Saint Joseph, MN 56374

RE: Project Number(s) SL33167015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 28, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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 may be 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.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
MDH may impose 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. MDH 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 (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 survey:

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33167	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY PLACE ON 7TH	329 7TH AVENUE SE SAINT JOSEPH, MN 56374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33167015 On February 26, 2024, through February 28, 2024, 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 47 residents; 33 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all of the licensee's residents, staff and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: LALD-H had a Health Service Executive license, effective through June 30, 2024; however, LALD-H's license lacked the licensee listed as the Director of Record with BELTSS. During the entrance conference on February 26, 2024, at 9:40 a.m., clinical nurse supervisor (CNS)-A stated LALD-H "took over" at the facility in September 2023, when the previous LALD resigned. CNS-A stated she was aware LALD-H's license lacked the licensee listed as the Director of Record with BELTSS, and had contacted LALD-H that morning to make sure he took care of this as soon as possible.	0 110		

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0 110	Continued From page 2 The licensee's Assisted Living Director policy, dated August 2021, indicated the licensee was required to have an LALD permitted by BELTSS; however, lacked direction to list as the Director of Record for the facility. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents;	0 470		

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0 470	Continued From page 3 (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan for determining the staffing level, that included an evaluation conducted at least twice a year of the appropriateness of staffing levels in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 26, 2024, at 1:40 p.m., clinical nurse supervisor (CNS)-A provided the licensee's Staffing Plan, dated February 9, 2024. When the surveyor asked to review the staffing plan prior to the current plan, CNS-A provided a Staffing Plan dated August 30, 2022. CNS-A stated she started at the facility in September 2023, and could not explain why the staffing plan was not reviewed at least twice a year, as required. The licensee's Staffing Plan - Assisted Living policy, effective February 2024, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provided adequate number of qualified direct care staff to	0 470		

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0 470	Continued From page 4 meet the residents' needs 24 hours a day, 7 days a week; however, the policy did not indicate the staffing plan would be reviewed at least two times a year, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR), dated February 26, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 5 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu was prepared a week in advance and made available to the residents. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a	0 485		

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0 485	Continued From page 6 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the initial tour on February 26, 2024, at 10:50 a.m., with clinical nurse supervisor (CNS)-A, the surveyors observed a menu posted on a board by the elevator, in the common area near the dining room. The menu included breakfast, lunch, and supper for the current week, Sunday through Saturday. During an interview on February 26, 2024, at 3:09 p.m., R1 showed the surveyor the menu for the current week, and stated the staff delivered the menu for the next week "a day or two or sometimes later," before the next week started, and clarified the menu started on Sunday and residents received the menu on the preceeding Friday or Saturday, and sometimes not until the new week started. On February 27, 2024, at 10:15 a.m., cook (C)-I provided the current week menu and the menu for the upcoming week to the surveyor. C-I stated residents received the menu for next week on Thursday or Friday, once food supplies were received for the next week so they could ensure they were able to provide the menu items. C-I stated next week's menu was not available to residents a week in advance, as required. The licensee's Food Service & Menu Planning policy, dated August 2021, indicated menus would be prepared at least one (1) week in advance and made available to all residents.	0 485		

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0 485	Continued From page 7 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control, as directed by the Centers for Disease Control and Prevention (CDC) including hand hygiene for one of four employees (unlicensed personnel/ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 510		

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0 510	Continued From page 8 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: INFECTION PREVENTION AND CONTROL PROGRAM The licensee lacked written evidence of an infection control program to include: - resident and family education; and - performance and monitoring feedback, including identification and monitoring adherence to infection prevention practices and infection control requirements, monitoring the incidence of infections that may be related to care provided at the facility, and acting on data and use of the information collected through surveillance to detect transmission of infectious agents in the facility. On February 28, 2024, at 1:02 p.m., clinical nurse supervisor (CNS)-A stated the infection control program lacked the above required content. CNS-A stated the tracking of infections for staff is on the OSHA form, and residents information is in their medical records. CNS-A added no audits had been completed for adherence to infection control practices. HAND HYGIENE On February 27, 2024, at 7:05 a.m., the surveyor observed ULP-D provide cares to R7 in his apartment. ULP-D assisted R7 to apply his stockings and shoes on each foot, donned (applied) new gloves, administered eye drops to both eyes, removed the gloves, touched her iPad, brought the laundry cart out, opened the door, and placed the cart in the laundry room. At 7:10 a.m., ULP-D entered R8's apartment. ULP-D opened the front door, opened the cabinet door in	0 510		

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0 510	Continued From page 9 the kitchen and the safe to remove the medications, placed the pills in a medication cup, and brought them to R8 to take the medications. After all medications were taken, ULP-D signed off on the iPad, placed the medication cards back in the safe, closed the doors, opened the unit door, and exited the room. On February 27, 2024, at 11:45 a.m., ULP-D stated she should be better about using gloves and washing her hands. ULP-D stated she was trained to wash her hands between each resident. On February 27, 2024, at 12:25 p.m., CNS-A stated staff are trained to do hand hygiene between residents, before and after glove use, and before administering eye drops. The licensee's Hand Washing policy, dated August 2021, noted proper hand washing techniques should be used to protect the spread of infection, and should be completed before donning and after removing gloves. The CDC, "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.1-2 reads: 1.) Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body	0 510		

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0 510	Continued From page 10 site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.	0 650		

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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
0 650	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for four of four employees (registered nurse (RN)-B, unlicensed personnel (ULP)-E, ULP-F, clinical nurse supervisor (CNS)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RN-B RN-B was hired on January 3, 2024, to provide direct care services to residents of the facility. Throughout the survey on February 26, 2024, through February 28, 2024, the surveyor observed RN-B while interacting with residents. RN-B's employee record lacked documentation of the following: - records of orientation to include handling of residents' complaints, reporting of complaints, and where to report complaints. ULP-E ULP-E was hired on May 12, 2023, to provide direct care services to residents of the facility. On February 27, 2024, at 7:23 a.m., the surveyor	0 650		

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	33167	A. BUILDING: _____ B. WING _____	02/28/2024

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0 650	Continued From page 12 observed while ULP-E administered oral medications to R5 and R6. ULP-E's employee record lacked documentation of the following: - records of orientation to include an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person, and handling of residents' complaints, reporting of complaints, and where to report complaints. On February 28, 2024, at 12:12 p.m., clinical nurse supervisor (CNS)-A stated the required information was discussed during orientation; however, stated, "It's not documented." ULP-F ULP-F started employment on May 30, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-F's record lacked: - documentation of annual performance reviews that identified areas of improvement needed and training needs. On February 28, 2024, at 12:37 p.m., CNS-A stated annual reviews were not being completed by the previous CNS. CNS-A CNS-A was hired on September 18, 2023, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. CNS-A's record lacked: - a current job description, including qualifications, responsibilities, and identification of	0 650		

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0 650	Continued From page 13 staff persons providing supervision; - records of orientation including overview of Assisted Living statutes, an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person, and handling of residents' complaints, reporting of complaints, and where to report complaints. CNS-A's record contained a job description for the position title of assisted living director. On February 28, 2024, at 12:27 p.m., CNS-A stated she had taken a few classes for the assisted living director, but was not licensed or in residency. CNS-A stated that was the job description she was given to sign. In addition, she stated she had received the orientation requirements, but it was not documented in her employee file. The licensee's Employee File - Employee Records policy, dated May 2023, indicated employee records for each person would include: - records of all training and in-service education required and/or provided including record of competency testing as required; - current signed job description, which included qualifications, responsibilities, and identification of supervisors, if any; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 660	Continued From page 14	0 660		
0 660 SS=F	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). This included documentation of a completed health history and symptom screening for two of four employees (registered nurse (RN)-B, unlicensed personnel (ULP)-E) and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of four employees (RN-B, ULP-E). 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	0 660		

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0 660	Continued From page 15 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 26, 2024, at 9:40 a.m., a request was made to review the facility TB risk assessment. The TB risk assessment provided was dated January 4, 2024, and indicated the licensee was a "low risk." RN-B RN-B had a hire date of January 3, 2024, to provide services under the licensee's Assisted Living license to the licensee's residents. RN-B's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs), dated February 28, 2023, and two negative TST results, dated March 3, 2023, and March 19, 2023, or 306 days prior to hire. ULP-E ULP-E had a hire date of May 12, 2023, to provide services under the licensee's Assisted Living license to the licensee's residents. ULP-E's employee record included documentation of a Baseline TB Screening Tool for Healthcare Workers (HCWs), dated February 13, 2024 (277 days after hire), and documentation of a TST, given February 13, 2024, with negative results documented and documentation of a TST, given February 27, 2024 (after initiation of survey), with pending results; however, the record lacked evidence the required screenings were completed upon hire, as	0 660		

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0 660	Continued From page 16 required. On February 28, 2024, at 12:12 p.m., clinical nurse supervisor (CNS)-A stated RN-B's TB results were obtained from a previous employer and were not dated within 90 days of hire, as required. CNS-A stated they realized ULP-E's TB screening had been missed when hired, and were in the process of ensuring that was completed. The licensee's Tuberculosis, Employee Screening For policy, effective January 2023, indicated all employees were screened for latent tuberculosis infection (LTBI) and active TB disease using TST, interferon gamma release assay (IGRA) (blood test for TB), and symptom screening, prior to beginning employment. The policy incorrectly directs, "If the baseline test is negative and the individual risk assessment indicates no risk factors for acquiring TB, then no additional screening is indicated," and, "If the baseline test is positive, but the individual risk assessment is negative and the individual is asymptomatic, a second test (either TST or IGRA) is conducted." Also included, "The Employee Health Coordinator (or designee) will accept documented verification of TST or IGRA results within the preceding 90 days." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering	0 660		

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0 660	Continued From page 17 either a two-step TST or single IGRA. Also included, an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680		

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0 680	Continued From page 18 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. In addition, the licensee failed to evaluate the missing resident plan at least quarterly. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour with clinical nurse supervisor (CNS)-A on February 26, 2024, at 10:50 a.m., the surveyors observed the facility's layout including three levels. The main level included a large entry area, large dining room, kitchen, and hallway with resident apartments. The second and third floors included resident apartments, and the third floor had a large common area. The building had one elevator in the middle of the building. The licensee's emergency preparedness binder	0 680		

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0 680	Continued From page 19 dated reviewed December 2023 included a Hazard Vulnerability Assessment. The EPP lacked the following required content: - policy and procedure to track the location of staff whether evacuated or sheltered in place; and - a communication plan that included the names and contact information for residents' physicians. On February 28, 2024, at 12:47 p.m., CNS-A stated the missing resident policy was reviewed annually, not quarterly. In addition, CNS-A stated she was unable to find the missing required content. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone	0 730		

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0 730	Continued From page 20 number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and	0 730		

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0 730	Continued From page 21 (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R4 admitted to the facility on October 25, 2022, and discharged on July 26, 2023. R4's diagnoses included hypertension (high blood pressure). R4's Service Plan dated February 9, 2023, noted services including assistance with housekeeping, meals, laundry, and medication administration. R4's record lacked a discharge summary including: - a summary of the resident's stay including diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the	0 730		

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0 730	Continued From page 22 latest assessment or review including baseline and current mental, behavioral, and functional status. On February 26, 2024, at 1:15 p.m., clinical nurse supervisor (CNS)-A stated no discharge summary had been completed for this resident by the prior nurse, and should have been. The licensee's Resident Record - Information and Content policy, dated August 2021, noted a discharge summary including service termination notice and related documentation when applicable. Minnesota Rules Chapter 4659.0120 Subp. 9, noted at the time of discharge, the facility must provide the resident, and with the resident's consent, the resident's representatives and case manager, with a written discharge summary including a summary of the resident's stat that includes diagnoses, course of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results, and a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident's status, including baseline and current mental, behavioral, and functional status. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a	01060		

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01060	Continued From page 23 resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process	01060		

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01060	Continued From page 24 in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R4 admitted to the facility on October 25, 2022, and discharged on July 26, 2023. R4's diagnoses included hypertension (high blood pressure). R4's Service Plan dated February 9, 2023, noted services including assistance with housekeeping, meals, laundry, and medication administration. R4's Resident Notes dated July 26, 2023, noted R4 was sent to the emergency room via ambulance. R4's record lacked evidence of a written notice provided to the resident, the resident's legal representative, and designated representative	01060		

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01060	Continued From page 25 that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R4's record lacked notification to the OOLTC that R4 had been relocated and had not returned to the facility within four days. On February 26, 2024, at 1:15 p.m., clinical nurse supervisor (CNS)-A stated she was aware of the requirement to provide the information, but said it was not completed by the previous CNS. The licensee's Emergency Relocation policy, dated September 2022, noted in the event of an emergency relocation, the licensee would provide written notice to include: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide	01060		

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	33167	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY PLACE ON 7TH	329 7TH AVENUE SE SAINT JOSEPH, MN 56374

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01060	Continued From page 26 housing or services after a relocation, the resident has the right to appeal. In addition, the policy noted the notice would be delivered to the OOLTC if the resident had been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of	01380		

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01380	Continued From page 27 two unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E's employee record lacked evidence to indicate the employee completed training as required in the following areas: - recognizing physical, emotional, cognitive, and developmental needs of the resident. ULP-E had a start date of May 12, 2023, to provide assisted living services to the licensee's residents. On February 27, 2024, at 7:23 a.m., the surveyor observed while ULP-E administered oral medications to R5 and R6. ULP-E's employee's record contained documents which listed training and demonstration topics; however, lacked information related to the above required training. On February 28, 2024, at 12:26 p.m., clinical nurse supervisor (CNS)-A and regional registered nurse (RRN)-C stated the above required content was not included during the in-person orientation class and stated the training was not included in the assigned modules that employees reviewed independently.	01380		

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01380	Continued From page 28 The licensee's Competency Training Evaluations policy dated August 2021, indicated training and competency evaluations for all ULPs would include: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01500		

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01500	Continued From page 29 (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01500		

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01500	Continued From page 30 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of four employees (unlicensed personnel/ULP-F). 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 started employment on May 30, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-F's record lacked documented evidence of the following required annual training: - a review of the provider's policies and procedures. On February 28, 2024, at 12:37 p.m., clinical nurse supervisor (CNS)-A stated she was in the process of doing employee record audits, and this will be included.	01500		

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01500	Continued From page 31 The licensee's Orientation of Staff and Supervisors & Content policy dated August 2021, noted all staff providing and supervising direct services must complete an orientation to Assisted Living facility requirements before providing services to residents, and the orientation would include an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.	01640		

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01640	Continued From page 32 (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included type 2 diabetes, volume overload (too much fluid in the body), chronic acquired lymphedema (tissue swelling in arms or legs), and chronic ulcer of skin. R1's Service Plan (Waiver) - Addendum to Contract, effective November 13, 2023, indicated R1 received services that included assistance with bathing, continuous positive airway pressure (CPAP)/bilevel positive airway pressure (BI-PAP) (machines used to improve sleep quality) cleaning, meals, blood glucose monitoring, housekeeping, and daily well being checks. The service plan included a section titled Individual Treatment and Therapy Management Plan, which indicated, "Included in the services listed below are all treatments and/or therapies the facility-trained staff is providing to the resident,	01640		

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01640	Continued From page 33 including the nurse supervision of those treatments and therapies." The service plan lacked documentation of all of R1's therapy or treatment management services. R1's MD (medical doctor) Orders, signed by prescriber December 12, 2023, included, "Please help [R1] apply pneumatic compression device daily for 30-60 minutes. Please apply compression stockings afterwards." R1's MD Contact, signed January 26, 2024, included new diagnoses including tinea pedis (fungal infection between toes), edema of legs, and dry skin, and new orders including "Epsom salt for daily foot soaks." R1's Individualized Treatment and Therapy Plan, last updated January 24, 2024, and printed February 27, 2024, unlicensed personnel (ULP) to gently wash and dry feet well in the morning, apply gauze between the first and second toes, and apply miconazole (topical antifungal) cream to the left foot. Also included, ULP were directed to remove gauze and soak feet for 10 minutes with Epsom salt in the evening, and to notify the registered nurse (RN) if concerns were noted such as signs/symptoms of infection. The plan directed the RN should supervise the skin care to R1's left foot. On February 28, 2024, at 9:03 a.m., the surveyor observed while ULP-J applied full leg sleeve compression devices to R1's bilateral legs. At 9:37 a.m., the surveyor observed while ULP-J removed the devices per R1's request. On February 28, 2024, at 11:44 a.m., clinical nurse supervisor (CNS)-A and regional RN (RRN)-C stated an assessment was completed	01640		

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01640	Continued From page 34 on February 22, 2024, after the initiation of the treatments noted above, and stated the service plan lacked documentation of the treatments being provided. RRN-C stated the service plan should have been revised to reflect the current services. The licensee's Service Plan policy, dated September 2022, indicated service plans shall be revised, if needed, based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910		

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01910	Continued From page 35 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record, the disposition of the medications with the required content for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R4 admitted to the facility on October 25, 2022, and discharged on July 26, 2023. R2's diagnoses included hypertension (high blood pressure). R4's Service Plan dated February 9, 2023, noted services including assistance with housekeeping, meals, laundry, and medication administration. R2's record lacked a discharge summary. On February 26, 2024, at 1:15 p.m., clinical nurse supervisor (CNS)-A stated the prior nurse did not complete a disposition of medications as required. The licensee's Medication Disposal policy dated	01910		

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01910	Continued From page 36 August 2021 noted upon disposition, the facility would document the disposition of the medications including the medication name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy	01940		

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01940	Continued From page 37 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 26, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-A indicated the licensee provided treatment and therapy management services to the licensee's residents, including blood glucose checks, oxygen assistance, compression stockings, ace wraps, modified diets, continuous positive airway pressure (CPAP)/bilevel positive airway pressure (BI-PAP) (machines used to improve sleep quality), orthotic braces, wound care, and catheters.	01940		

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01940	Continued From page 38 On February 28, 2024, at 9:03 a.m., the surveyor observed while unlicensed personnel (ULP)-J applied full leg sleeve compression devices to R1's bilateral legs. At 9:37 a.m., the surveyor observed while ULP-J removed the devices per R1's request. R1's diagnoses included type 2 diabetes, volume overload (too much fluid in the body), chronic acquired lymphedema (tissue swelling in arms or legs), chronic ulcer of skin, and chronic obstructive pulmonary disease. R1's Service Plan (Waiver) - Addendum to Contract, effective November 13, 2023, indicated R1 received services that included assistance with bathing, CPAP/Bi-PAP, cleaning, meals, blood glucose monitoring, housekeeping, and daily well being checks. R1's MD (medical doctor) Orders, signed by prescriber December 12, 2023, included, "Please make sure [R1] is on a low calorie, low salt diabetic diet. Only sugar free snacks. Please help [R1] apply pneumatic compression device daily for 30-60 minutes. Please apply compression stockings afterwards." Also included, "CPAP/Bi-pap cleaning...2 [two] times per day, Daily," and "Record - Blood Glucose...3 [three] days a week." R1's MD Contact, signed January 26, 2024, included new diagnoses including tinea pedis (fungal infection between toes), edema of legs, and dry skin, and new orders including "Epsom salt for daily foot soaks." R1's Individualized Treatment and Therapy Plan (ITTP), last updated January 24, 2024, and printed February 27, 2024, directed ULP to gently	01940		

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SERENITY PLACE ON 7TH	329 7TH AVENUE SE SAINT JOSEPH, MN 56374

(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 39 wash and dry feet well in the morning, apply gauze between the first and second toes, and apply miconazole (topical antifungal) cream to the left foot. Also included, ULP were directed to remove gauze and soak feet for 10 minutes with Epsom salt in the evening, and to notify the registered nurse (RN) if concerns were noted such as signs/symptoms of infection. The plan directed the RN should supervise the skin care to R1's left foot. The plan lacked mention of dietary needs, compression device, compression stockings, CPAP/Bi-PAP, and blood glucose monitoring. R1's record lacked a treatment management plan to include the following required content: - a statement of the type of services that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - 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. On February 28, 2024, at 11:44 a.m., CNS-A and regional RN (RRN)-C stated R1's ITTP lacked documentation of all of the treatments being provided to R1, and stated the ITTP should include all treatments R1 was receiving and should include the required content.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33167	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY PLACE ON 7TH	329 7TH AVENUE SE SAINT JOSEPH, MN 56374

(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 40 The licensee's Treatment & Therapy Management Plan policy, effective August 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: - a statement of the type of services that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services; - 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud
320-223-7300

Type: Full
Date: *02/26/24*
Time: 11:10:50
Report: 1041241045

Food and Beverage Establishment Inspection Report

Location:
Serenity Place On 7th
329 7th Avenue Se
St Joseph, MN56374
Stearns County, 73

Establishment Info:
ID #: 0039039
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202713400
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

AT TIME OF INSPECTION, THE DISHWASHER WAS LEAKING AND IS NOT ABLE TO HIT 160 DEG. F. PARTS HAVE BEEN ORDERED. THEY WILL BE SANITIZING DISHES IN THE SINK UNTIL DISHWASHER IS REPAIRED.

Comply By: 02/26/24

2-100 Supervision

2-102.12AMN

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

KRISTIN EISENREICH HAS TAKEN THE SERVSAFE CLASS AND HAS APPLIED FOR THE STATE CERTIFICATE, BUT SHE HASN'T RECEIVED IT YET.

Comply By: 03/18/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

THERE WERE BOXES OF PASTA, CRACKERS, CANS OF BEANS, AND ICE CREAM SALT ON THE FLOOR OF THE DRY STORAGE AREA AND BOXES OF GARLIC TOAST AND BREADSTICKS ON THE WALK-IN FREEZER FLOOR. STORE FOOD ON SHELVES.

Type: Full
Date: *02/26/24*
Time: 11:10:50
Report: 1041241045
Serenity Place On 7th

Food and Beverage Establishment Inspection Report

Comply By: 02/27/24

Surface and Equipment Sanitizers

Acid: = 700 at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Hot Water: = at 140 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 35 Degrees Fahrenheit - Location: VEGETABLE SOUP
Violation Issued: No

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

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 1041241045 of 02/26/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed: Linda Heinen

Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us

Report #: 1041241045

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 02/26/24
Time In 11:10:50
Time Out

Serenity Place On 7th	Address: 329 7th Avenue Se	City/State: St Joseph, MN	Zip Code: 56374	Telephone: 3202713400
License/Permit #: 0039039	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Surpervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	IN	(OUT)	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	IN	OUT	(N/A)		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39	X	Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 02/26/24

Inspector (Signature) Linda Hinen