DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 4, 2023

Licensee
Ecumen Worthington The Meadows
1801 Collegeway
Worthington, MN 56187

RE: Project Number(s) SL20011015

Dear Licensee:

On December 22, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the November 3, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

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Electronically Delivered

November 30, 2022

Administrator
Ecumen Worthington The Meadows
1801 Collegeway
Worthington, MN 56187

RE: Project Number(s) SL20011015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 3, 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 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

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

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

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

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

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20011	A. BUILDING: _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN WORTHINGTON THE MEADOWS	1801 COLLEGEWAY WORTHINGTON, MN 56187

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20011015 On November 2, 2022, through November 3, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were sixty-two (62) residents, forty-eight (48) receiving services under the provider's Assisted Living Dementia Care license. Immediacy is removed as confirmed by review by evaluation supervisor on November 3, 2022, however noncompliance remains at a scope and severity of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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; (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 and interview, the licensee failed to ensure the staffing plan was posted for residents, staff, and visitors to review as required. 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	0 470		

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0 470	Continued From page 2 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: The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked - identify the direct-care staff member's resident assignments or work location - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building During observation on November 1, 2022, at 10:30 a.m., the surveyor did not observe a posted staff schedule in any area of the facility. On November 2, 2022, at 10:48 a.m., licensed assisted living director (LALD)-C stated there had been a staffing schedule posted at one time at the front entrance, but she felt that this was not appropriate and removed the schedule. LALD-C stated there was a staffing plan displayed in a plastic holder that defined how many staff members were needed to work on each shift. The form did not indicate the names of the staff members, nor the staff members work assignments for each of the determined shifts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 470		

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0 470	Continued From page 3 (21) 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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all sixty-two (62) residents in the Assisted Living Dementia Care 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) 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	0 480		

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0 480	Continued From page 4 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated November 2, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 infection control program that complies with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a	0 510		

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0 510	Continued From page 5 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect all staff, residents and visitors.) The findings include: On November 1, 2022, at approximately 11:48 a.m., the surveyor observed unlicensed personnel (ULP)-B provide medication administration to R8, which included oral medications, and prescription topical powder application. ULP-B did not perform hand hygiene when donning (putting on) and doffing (taking off) gloves. During observation on November 1, 2022, at approximately 11:48 a.m., ULP-B obtained R8's medications, and a prescription topical powder from the medication storage container. ULP-B then administered the oral medications to R8. ULP-B returned to the medication storage container on the kitchen counter and disposed of R8's medication cup. ULP-B donned gloves to both hands without application of any hand sanitizer or hand washing prior. ULP-B proceeded into the bedroom with R8 and assisted with positioning resident on the bed. R8 was laying on their back. ULP-B assisted R8 to lower their pants and undergarment. ULP-B applied a topical powder to the folds of the abdomen. When completed, ULP-B doffed their gloves and returned to the medication cart to document in the electronic medication administration record (MAR). ULP-B did not apply any hand sanitizer or perform hand washing after doffing gloves. ULP-B completed documentation in the MAR,	0 510		

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0 510	Continued From page 6 returned medications, and locked a cabinet. ULP-B proceeded to leave R8's room. On November 1, 2022, at approximately 12:20 p.m., registered nurse (RN)-D was notified of ULP-B not performing hand hygiene before or after application of donning or doffing gloves. RN-D stated all ULPs had been trained and instructed to wash hands by the licensed practical nurse (LPN) after every application of donning or doffing gloves. The licensee's Handwashing policy dated May 2015, indicated handwashing would be performed before and after any direct contact with a client and after removing gloves. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	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;	0 650		

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0 650	Continued From page 7 (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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included an annual performance review for one of two employees (registered nurse (RN)-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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A had a hire date of February 16, 2018. RN-A's employee record lacked evidence an annual performance review was completed.	0 650		

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0 650	Continued From page 8 On November 1, 2022, at 1:18 p.m., RN-A and RN-D both stated they believed RN-A had a performance review completed and stated they would obtain the record for surveyor to view. The licensee's Performance Review policy dated May 2015, indicated a performance review would be conducted at least annually on the employee's anniversary date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680		

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0 680	Continued From page 9 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 post an emergency preparedness plan prominently. This had the potential to impact all residents, staff, and visitors to the licensee's 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), 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 November 1, 2022, at 12:15 p.m. during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted in a prominent location. On November 2, 2022, at approximately 9:10 a.m., the surveyor requested the licensee's emergency disaster or preparedness plan. Licensed assisted living director (LALD)-C provided a red binder consisting of all documents related to the licensee's emergency management plan. During an interview on November 2, 2022, at	0 680		

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0 680	Continued From page 10 approximately 11:15 a.m., LALD-C stated she had posted the emergency preparedness information and proceeded to bring surveyor to the area where it was posted. Emergency preparedness information was posted in an alcove area of the south building and was not in a prominent location for staff and visitors to view. The licensee's undated Emergency Preparedness policy did indicate the licensee would have a written plan of action posted to facilitate residents' care and services in response to a natural disaster or any type of emergency that may affect their ability to provide services. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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	0 800		

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	20011	A. BUILDING: _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN WORTHINGTON THE MEADOWS	1801 COLLEGEWAY WORTHINGTON, MN 56187

(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
0 800	Continued From page 11 residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on November 1, 2022, at approximately 11:00 a.m. with Licensed Assisted Living Director (LALD)-C and Environmental Services (ES)-F, the following items were observed: - The south building second floor computer room had an extension cord with an altered plug powering the permanently installed exhaust fan. The cord was also cut in the middle and had an open-air splice in the middle of the cord. Electric cords are not allowed to be a power source for permanently installed equipment, all electrical splices or junctions must be made within a listed box, and cutting and replacing the cord end violates the listing and safety of the cord. - The main building first floor laundry room had considerable damage to sheetrock ceiling by the light with evidence of water damage. LALD-C and ES-F visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		

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0 800	Continued From page 12 days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees 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	0 810		

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0 810	Continued From page 13 by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on November 1, 2022, at approximately 10:20 a.m. with Licensed Assisted Living Director (LALD)-C and Environmental Services (ES)-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD-C and ES-F verified that the fire safety and evacuation plan for the facility lacked these	0 810		

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0 810	Continued From page 14 provisions. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. During interview, LALD-C and ES-F verified that there were no further documented drills for the facility other than what was provided and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01370 SS=F	144G.61 Subd. 2 (a) 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	01370		

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01370	Continued From page 15 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 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluation were completed by a registered nurse (RN), or another instructor in conjunction with the RN, for one of one unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP- B was hired on August 24, 2022. ULP-B's training record lacked documentation of	01370		

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01370	Continued From page 16 completed training and competency by a RN, or another instructor in conjunction with the RN, for the following: - documentation requirements for all services provided; - maintenance of a clean and safe environment; - medication, exercise, and treatment reminders; - 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; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. During interview on November 1, 2022, RN-A stated licensed practical nurse (LPN)-G provided ULPs with orientation and all required trainings. RN-A stated she was at one time responsible to provide training and orientation to ULPs but LPN-G had assumed the responsibility. RN-A stated she was responsible to ensure LPN-G completed documentation indicating all training and orientation were completed. RN-A stated she was not involved in any of the training. On November 2, 2022, at 9:30 a.m., ULP-B stated they were trained by LPN-G in the above identified areas prior to providing services to residents. ULP-B stated they were trained and oriented to the needs of residents by LPN-G. ULP-B stated neither RN-A nor RN-D were involved in any training or orientation. On November 2, 2022, at 10:20 a.m., RN-D stated RN-A was involved in assisting with	01370		

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01370	Continued From page 17 orientation and required training. RN-D stated RN-A and ULP-B were incorrect in their responses. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated May 2015, indicated training and competency evaluations of unlicensed personnel must be conducted by an RN or there instructor in conjunction with the RN. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	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:	01380		

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01380	Continued From page 18 Based on interview and record review, the licensee failed to ensure training and competency evaluation were completed by a registered nurse (RN), or another instructor in conjunction with the RN, for one of one unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B had a hire date of August 24, 2022. ULP-B's training record lacked documentation of completed training and competency by a RN, or another instructor in conjunction with the RN, for the following: - observation, reporting, and documenting status, - basic body knowledge, - recognizing needs, - safe transfers, and - range of motion. During interview on November 1, 2022, RN-A stated licensed practical nurse (LPN)-G provided ULPs with orientation and all required trainings. RN-A stated she was at one time responsible to provide training and orientation to ULPs but LPN-G had assumed the responsibility. RN-A stated she was responsible to ensure LPN-G completed documentation indicating all training and orientation were completed. RN-A stated she was not involved in any of the training.	01380		

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01380	Continued From page 19 On November 2, 2022, at 9:30 a.m., ULP-B stated they were trained by LPN-G in the above identified areas prior to providing services to residents. ULP-B stated they were trained and oriented to the needs of residents by LPN-G. ULP-B stated neither RN-A nor RN-D were involved in any training or orientation. On November 2, 2022, at 10:20 a.m., RN-D stated RN-A was involved in assisting with orientation and required training. RN-D stated RN-A and ULP-B were incorrect in their responses. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated May 2015, indicated training and competency evaluations of unlicensed personnel must be conducted by an RN or there instructor in conjunction with the RN. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (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	01440		

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01440	Continued From page 20 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 delegated tasks within 30 days of providing services for one of one unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B had a hire date of August 24, 2022. ULP-B was hired to provide direct care and services to the licensee's residents. ULP-B's employee record lacked documentation of an RN supervising ULP-B performing delegated tasks	01440		

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01440	Continued From page 21 within 30 days of providing delegated services. During an interview on November 2, 2022, at 11:20 a.m., RN-A stated that she did not conduct official 30-day supervisory evaluations of ULPs performing delegated tasks. RN-A stated licensed practical nurse (LPN)-G was responsible for completing the supervisory visits. During interview on November 2, 2022, at 11:22 a.m., LPN-G confirmed that she was responsible for conducting ULPs official 30-day supervisory evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01750 SS=I	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 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 interview and record review, the licensee failed to ensure prior to delegating the	01750		

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01750	Continued From page 22 task of medication administration, the unlicensed personnel (ULPs) had demonstrated the ability to competently follow the procedures to a registered nurse (RN) for one of one employee (ULP-B). 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: ULP-B started employment with the licensee on August 29, 2022. ULP-B's employee record indicated she had received training for the administration of oral, topical, and injectable medications on September 20, 2022. ULP-B's employee record indicated ULP-B had demonstrated competency to licensed practical nurse (LPN)-G, for the administration of oral, topical, and injectable medications on September 20, 2022. During entrance conference on November 1, 2022, at 10:45 a.m., registered nurse (RN)-D stated ULP training in medication administration and competency testing was completed by LPN-G. RN-D stated LPN-G's documentation was reviewed by a RN for accuracy and to ensure all areas of medication administration and competency testing were completed. During observation on November 1, 2022, at 11:40 a.m., ULP-B administered medications to	01750		

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01750	Continued From page 23 R8, which included oral and topical medications. During interview on November 1, 2022, at 1:40 p.m., RN-A stated LPN-G completed all competency training and testing in medication administration to ensure ULPs were competent in completing the task. RN-A stated she used to do the training but had stopped and LPN-G assumed the responsibility of training and testing ULPs for competency. RN-A was not sure as to why this process was changed. During interview on November 2, 2022, at 9:38 a.m., ULP-B stated LPN-G had instructed ULP-B in the tasks of medication administration and had viewed ULP-B demonstrating competency on the delegated tasks of medication and treatment administration. ULP-B stated an RN was not present to view her demonstrating competency on any delegated tasks. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated May 25, 2015, indicated ULPs will meet all orientation and training requirements and will be determined to be competent to perform all assigned tasks by the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On November 3, 2022, the immediacy of correction order 1750 was removed. TIME PERIOD FOR CORRECTION: Seven (7) Days	01750		

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02040	Continued From page 24	02040		
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: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted November 1, 2022, at approximately 10:20 a.m. with Licensed Assisted Living Director (LALD)-C	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20011	A. BUILDING: _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN WORTHINGTON THE MEADOWS	1801 COLLEGEWAY WORTHINGTON, MN 56187

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 25 and Environmental Services (ES)-F on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-C stated the facility had conducted this assessment but was not able to provide documentation or locate the assessment at the time of survey. LALD-C verified that the licensee was not able to provide a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *11/02/22*
Time: 12:31:59
Report: 1028221177

Food and Beverage Establishment Inspection Report

Location:
Ecumen Worthington The Meadows
1801 College Way
Worthington, MN56187
Nobles County, 53

Establishment Info:
ID #: 0026245
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Ecumen

Phone #: 5073306718
ID #: 07148

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.

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

Food prepared in the establishment more than 7 days ago must be discarded.

Corrected on Site

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

The blade of the stationary can opener in the main kitchen and serving kitchen must be cleaned to remove food debris.

Comply By: 11/03/22

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

The shelving in the refrigerator in the memory care kitchenette must be cleaned to remove food debris and mold-like residue.

Comply By: 11/03/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

Provide a handwashing sign at the handwashing sink in the memory care kitchenette.

Comply By: 11/03/22

Surface and Equipment Sanitizers

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

Hot Water: = at 188 Degrees Fahrenheit
Location: Dish Machine - Rinse
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: -5 Degrees Fahrenheit - Location: Victory - Ambient
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -20 Degrees Fahrenheit - Location: Arctic Air - Ambient
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Roast Beef
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: Sliced Tomatoes
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 5 Degrees Fahrenheit - Location: Saturn - Ambient
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: Traulsen - Ambient
Violation Issued: No

Type: Full
Date: *11/02/22*
Time: 12:31:59
Report: 1028221177
Ecumen Worthington The Meadows

Food and Beverage Establishment Inspection Report

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

This Inspection was conducted in conjunction with HRD.

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221177 of 11/02/22.

Certified Food Protection Manager: Nancy Ward

Certification Number: FM8416 Expires: 02/28/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Nancy Ward
Culinary Director

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