Electronically Delivered

July 26, 2023

Licensee
Poplar Meadows Of McIntosh
325 Scots Avenue Southeast
McIntosh, MN 56556

RE: Project Number(s) SL30294015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 12, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30294	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR MEADOWS OF MCINTOSH	325 SCOTS AVENUE SE MCINTOSH, MN 56556

(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: SL30294015-0 On July 10, 2023, through July 12, 2023, 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 26 active residents; 19 receiving services under the Assisted Living with Dementia Care 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (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 interview and record review, the licensee failed to ensure one or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents, were 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. In addition, the licensee failed to ensure a staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors.	0 470		

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0 470	Continued From page 2 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: The licensee held an Assisted Living Dementia Care (ALDC) license with a capacity of 32 residents. The current census was 26 residents, with 19 residents receiving assisted living services. Of the 26 residents, seven residents resided in the secure unit and 19 residents resided in the unsecure unit. STAFFING PLAN During the entrance conference on July 10, 2023, at 10:17 a.m., licensed assisted living director (LALD)-A stated the usual staffing schedule for the facility was as follows: - the clinical nurse supervisor (CNS)-B was on site Monday through Thursday 8:00 a.m. to approximately 4:30 p.m. - the day shift was staffed with two unlicensed personnel (ULP) from 6:00 a.m. to 6:00 p.m., one ULP was assigned to the secure unit and one ULP was assigned to the unsecure unit - the night shift was staffed with one ULP from 6:00 p.m. to 6:00 a.m., this ULP was assigned to the secure unit and was not to leave the secure unit. LALD-A stated there was not an ULP assigned to the unsecure unit of the facility from 6:00 a.m. to 6:00 p.m. LALD-A stated if a resident in the unsecure unit requested assistance during these	0 470		

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0 470	Continued From page 3 hours; the residents contacted the ULP in the secure unit via the facility's call system which either went to a pager or portable telephone the ULP carried. The ULP then would either make the decision if the on-call registered nurse (RN) needed to be notified and/or if 911 needed to be called. LALD-A stressed the ULP was not to leave the secure unit unattended. LALD-A stated none of the residents at the facility required a two person assist with transferring. LALD-A stated the licensee was in the process of changing their category of facility license from ALDC to an Assisted Living Facility (ALF). LALD-A stated she had been in contact with the Minnesota Department of Health (MDH) and had submitted the paperwork requested to make this change about ten days ago. The facility's staffing plan last reviewed February 27, 2023, indicated the following: - "Main Floor" (unsecure unit) - ULP on duty seven days a week 6:00 a.m. to 6:00 p.m. - "Memory Care Unit" (secure unit) ULP on duty seven days a week 24 hours a day (shifts are 6:00 a.m. to 6:00 p.m., and 6:00 p.m. to 6:00 a.m.) - nursing hours - Monday - Friday 8:00 a.m. to 4:00 p.m. - nurse on call 24/7 - CNS and/or registered nurse (RN) available 24/7 The facility's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated February 15, 2023, indicated the facility held an ALDC license. ULP were in the building and available to respond to resident requests 24/7. The number of unlicensed direct care staff typically scheduled for the day shift were two and the number for night shift was one.	0 470		

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0 470	Continued From page 4 The licensee's assisted living contract indicated under the "Assisted Living Services" header ULP staff were on the premises round the clock, seven days a week, with an ULP on the unsecure unit 7:00 a.m. to 7:00 p.m. and an ULP in the secure unit 24 hours a day. After 7:00 p.m. the resident on the unsecure unit could contact the ULP in the secure unit for assistance, but the ULP stays on the secure unit and does not leave unless an emergency. On July 11, 2023, at 5:35 a.m., ULP-F was observed in the secure unit. ULP-F stated she worked fulltime on the night shift on the secure unit. ULP-F stated she was "not allowed to leave" the secure unit. ULP-F stated there was always one staff member scheduled for the night shift (6:00 p.m. to 6:00 a.m.). ULP-F stated she was responsible for responding to calls from the unsecure unit during her shift. ULP-F stated she received calls either to her pager or her cordless telephone depending on what call system the resident used. ULP-F stated when she received a call, she would ask the resident if they needed to call 911 and if the resident felt they needed immediate assistance; then she would direct the resident to call 91. ULP-F stated she would then notify the RN on call of the situation. ULP-F stated the RN would come in if needed. ULP-F stated if when a resident called and they were unable to communicate with her, then she would call 911. ULP-F stated she rarely received a call from residents on the unsecure unit during the night shift. ULP-F stated it only occurred about once every two to three months. On July 11, 2023, at 8:48 a.m., LALD-A stated she was unaware if the facility had a staffing waiver. LALD-A stated if needed the on-call RN	0 470		

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0 470	Continued From page 5 could be at the facility within 15 minutes. STAFF POSTING On July 10, 2023, at 10:39 a.m., during a tour of the facility with LALD-A the surveyor did not observe a posted staff schedule. LALD-A stated the schedule was in the ULP office area. LALD-A stated the staffing plan was posted by the main entrance; however, the daily staff schedule was not prominently posted for residents and visitors. The licensee's Staffing and Scheduling policy dated August 1, 2021, noted the CNS would develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. Minnesota Rules - Assisted Living Facilities 4659.0180 Staffing, subdivision (4) (B) indicates a daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 470		

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0 480	Continued From page 6	0 480		
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 included document titled, Food and Beverage Establishment Inspection Report dated July 10, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances.	0 550		

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0 550	Continued From page 7 The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. 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) 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 July 10, 2023, at 10:42 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. The bulletin board by the main entrance had the facility's grievance procedure (Complaint Resolution Process) posted; however, the grievance procedure posted did not include the required content to include the contact information for the Office for Mental Health and Developmental Disabilities and the e-mail contact	0 550		

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0 550	Continued From page 8 information for LALD-A who was listed as the individual responsible for handling complaints. LALD-A stated the above noted information was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
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 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.	0 680		

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0 680	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to prominently post a written emergency preparedness plan (EPP). This had the potential to affect all residents, staff, and visitors of 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), 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 July 10, 2023, at 10:42 a.m., a facility tour was conducted with licensed assisted living director (LALD)-A. The surveyor did not observed signage posted or information regarding the licensee's EPP in the common areas of the facility. On July 10, 2023, at 11:23 a.m., LALD-A stated the EPP binder was kept in the unlicensed personnel (ULP) office area. LALD-A confirmed the EPP was not posted in the common areas of the facility or signage indicating where the EPP was located so it would be available to all staff, residents, or visitors No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 800	Continued From page 10	0 800		
0 800 SS=D	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 residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On facility tour with the Maintenance Supervisor (Maintenance)-E between approximately 11:15 AM and 1:30 PM on July 10, 2023, it was observed that the trash chute door for the second floor did not close and positively latch as required as part of the fire rated shaft assembly. This	0 800		

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0 800	Continued From page 11 deficient condition was visually verified by Maintenance-E accompanying on the tour. It was also observed that the fusible link protected, chute closure door at the opening of the chute in the trash room was removed/missing. This feature of the chute is required to keep fire and smoke from entering the chute and spreading throughout the building. This deficient condition was visually verified by Maintenance-E accompanying on the tour. It was also observed in the memory care area of the facility, that potentially dangerous utensils were kept in an unsecured drawer within the kitchen. This deficient condition was visually verified by Maintenance-E accompanying on the tour. Additionally, the second-floor laundry room door was held open by a box to keep the door from closing. This door is required to be closed as it is a fire rated door in an exit corridor. This deficient condition was visually verified by Maintenance-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency;	0 810		

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POPLAR MEADOWS OF MCINTOSH	325 SCOTS AVENUE SE MCINTOSH, MN 56556

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0 810	Continued From page 12 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide required employee training on fire safety and evacuation. 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	0 810		

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0 810	Continued From page 13 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 July 10, 2023, between approximately 1:30 p.m. and 2:30 p.m. with the Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review indicated that employees did not receive training twice per year after initial hire. During interview, LALD-A stated she misunderstood the requirement and believed that training was only required once per year after hire. This deficient condition was verified by LALD-A during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of	0 930		

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0 930	Continued From page 14 residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the assisted living contract included all required content for two of two residents (R1, R2). 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 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: R1 R1's service plan dated December 29, 2022, indicated services included medication setup, medication administration, laundry, housekeeping, assistance with glucose monitoring, and assistance with dressing, grooming, toileting, and bathing. On July 10, 2023, at 2:51 p.m., the surveyor	0 930		

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0 930	Continued From page 15 observed unlicensed personnel (ULP)-C administer R1's scheduled afternoon medication. R2 R2's service plan dated April 12, 2023, indicated the resident received services which included medication setup, medication administration, laundry, housekeeping, and assistance with bathing. On July 11, 2023, at 8:10 a.m., the surveyor observed ULP-G administer R2's scheduled morning medications. R1 and R2's Assisted Living Housing and Services Contract (assisted living contract) dated December 29, 2021, and April 12, 2023, respectively, did not include the contact information for the Ombudsman for Mental Health and Developmental Disabilities. On July 11, 2023, at 1:12 p.m., license assisted living director (LALD)-A stated the assisted living contract was a template contract used by the licensee for all residents. LALD-A reviewed the contract and stated the contract did not include the above noted content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
01440 SS=D	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	01440		

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01440	Continued From page 16 registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one 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 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).	01440		

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01440	Continued From page 17 The findings include: ULP-D was hired on April 5, 2022, to provide direct care services to the facility's residents. On July 10, 2023, at 1:56 p.m., the surveyor observed ULP-D administer R5's scheduled afternoon medication. ULP-D's employee record did not include documentation of a registered nurse (RN) supervising ULP-D performing a delegated task within 30 days of beginning work with the licensee. On July 12, 2023, at 11:05 a.m., licensed assisted living director (LALD)-A stated a 30-day supervision had not been completed on ULP-D. The licensee's Supervision of Staff - Delegated Services policy dated August 1, 2021, noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working at the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter;	01470		

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01470	Continued From page 18 (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any 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	01470		

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01470	Continued From page 19 and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of two employees (clinical nurse supervisor (CNS)-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, 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: CNS-B was hired on October 15, 2019, and began providing assisted living services on August 1, 2021. CNS-B's employee orientation record did not include an overview of the 144G statutes as required.	01470		

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01470	Continued From page 20 On July 12, 2023, at 11:02 a.m., licensed assisted living director (LALD)-A stated the prior registered nurse (RN) had covered the 144G statutes with the unlicensed personnel staff, however, did not cover the 144G statutes with the licensed staff. LALD-A confirmed CNS-B had not completed the above noted required orientation. The licensee's Orientation of Staff and Supervisors and Content policy dated August 1, 2021, noted all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. The orientation must contain an overview of the appropriate Assisted Living statutes and rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 21 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool on day 14 for one of one resident (R2), and day 90 for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 - 14 DAY ASSESSMENT R2's diagnoses included congested heart failure (CHF- condition in which the heart's function as a pump is inadequate to meet the body's needs), hypertension (HTN- high blood pressure), muscle weakness, and atrial fibrillation (irregular often fast heart rate).	01620		

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01620	Continued From page 22 R2's service plan dated April 12, 2023, indicated the resident received services which included medication setup, medication administration, laundry, housekeeping, and assistance with bathing. On July 11, 2023, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R2's scheduled morning medications. R2's 14 Day Reassessment dated April 26, 2023, indicated the resident had changed her resuscitation status; was able to ambulate independently; had a good appetite; had a doctor's appointment on April 18, 2023, with no changes; was independent with personal cares and dressing; the RN setup R2's medications and the ULP administered the medications. This assessment did not include all the elements on the uniform assessment tool as required. R1 - 90 DAY ASSESSMENT R1's diagnoses included diabetes, depression, and history of alcohol abuse. R1's service plan dated December 29, 2022, indicated the resident received services which included medication setup, medication administration, laundry, housekeeping, assistance with glucose monitoring, and assistance with dressing, grooming, toileting, and bathing. On July 11, 2023, at 9:30 a.m., the surveyor observed ULP-H apply R1's TED hose (specially designed stockings that help prevent blood clots and swelling in legs); oversaw R1 conduct a blood glucose check; and ULP-H prepared R1's insulin pen which R1 self-administered.	01620		

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01620	Continued From page 23 R1's 90 Day Assessment dated March 23, 2023, indicated R1 continued to need the assist of one; monitored his own blood glucose checks four times daily; struggled with edema/weight in his extremities; continued to be incontinent; and had a good appetite. R1's 90 Day Assessment dated June 21, 2023, indicated R1 was started on two diuretics; continued to be weighed twice weekly; and ULP assisted R1 with personal cares and housekeeping. There were no changes made to R1's service plan. These assessments did not include all the elements on the uniform assessment tool as required. On July 11, 2023, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated the universal assessment tool was only completed on the initial assessment and the annual assessment. CNS-B stated the elements of the universal assessment tool were not reviewed during the time of a residents 14-day, 90-day, or a change of condition reassessment. The licensee's Uniform Assessment Tool policy dated August 1, 2021, noted [name of the facility] would use a uniform assessment tool that addressed all the required elements. Minnesota Rules - Assisted Living Facilities 4659.0150 Uniform Assessment Tool, subdivision 2 indicated each facility must develop a uniform assessment tool. The facility may use an acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. No further information was provided.	01620		

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01620	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
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. (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 service plans were updated for one of two 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	01640		

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01640	Continued From page 25 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 diabetes, depression, and history of alcohol abuse. On July 11, 2023, at 9:30 a.m., the surveyor observed unlicensed personnel (ULP)-H apply R1's knee high TED hose (specially designed stockings that help prevent blood clots and swelling in legs). R1's prescriber orders dated October 18, 2022, included an order for daily TED hose. R1's Treatment Administration Record (TAR) dated June 1, 2023, through July 10, 2023, indicated staff were applying R1's TED hose in the morning and removing them each evening. R1's service plan dated December 29, 2022, did not include daily TED hose application and removal. On July 11, 2023, at 1:41 p.m., clinical nurse supervisor (CNS)-B stated R1's service plan had not been revised to include TED hose. The licensee's Service Plan policy dated August 1, 2022, noted service plans will be revised, if needed, based on resident reassessments and monitoring. No further information was provided.	01640		

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	30294	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a medication management assessment was completed by the	01700		

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01700	Continued From page 27 registered nurse/RN to determine what medication management services would be provided and included identification and review in all required areas for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 10, 2023, at 9:59 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R2's diagnoses included congested heart failure (CHF- condition in which the heart's function as a pump is inadequate to meet the body's needs), hypertension (HTN- high blood pressure), muscle weakness, and atrial fibrillation (irregular often fast heart rate). R2's service plan dated April 12, 2023, indicated the resident received services which included medication setup and medication administration. R2's prescriber orders dated April 20, 2023, April 25, 2023, and April 26, 2023, included one bladder relaxant medication, one diuretic, one blood thinner, two antihypertensives, one medication to treat heart rhythm irregularities, one medication to treat heart burn, and two vitamin/mineral supplements.	01700		

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01700	Continued From page 28 On July 11, 2023, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R2's scheduled morning medications. R2's record lacked evidence the RN conducted a face-to-face assessment with the resident and/or their representative to include a review of all medications the resident was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions and interventions needed in management of medications to prevent diversion. On July 11, 2023, at 1:32 p.m., CNS-B stated R2 had not had a medication management services assessment completed to include all the above noted content. The licensee's Medication Management - Assessment, Monitoring and Reassessment policy dated August 1, 2021, indicated a medication management assessment would be conducted face-to-face with the resident by the RN. The assessment must include an identification and review of all medications the resident is known to be taking. The assessment must include indications for use, side effects, contraindications, allergic and adverse reactions, and actions to address these issues. The assessment must identify interventions needed in management of medications to prevent diversion. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas	01710		

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01710	Continued From page 29 The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of one resident (R1) who received medication management services. 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: During the entrance conference on July 10, 2023, at 9:59 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R1's diagnoses included diabetes, depression, and history of alcohol abuse. R1's service plan dated December 29, 2022, indicated the resident received services which included medication setup and medication	01710		

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01710	Continued From page 30 administration. R1's prescriber orders dated July 26, 2022, August 31, 2022, March 1, 2023, and April 17, 2023, included one mild pain reliever, one antihypertensive medication, two diuretics, one medication to treat heart burn, two antidepressants, one medication to treat nerve pain, one long-acting insulin, one oral and one injectable antidiabetic medication, one medication to treat urinary retention, one medication to treat high cholesterol, and one antihistamine. On July 10, 2023, at 2:51 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled afternoon medication. R1's record did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. On July 11, 2023, at 1:44 p.m., CNS-B reviewed R1's record and stated R1 had not had a medication management reassessment completed with the required content. CNS-B stated this had not been done by the previous RN. CNS-B stated this would be the same for all residents at the facility. The licensee's Medication Management - Assessment, Monitoring and Reassessment policy dated August 1, 2021, indicated a medication management assessment would be conducted face-to-face with the resident by the RN. The assessment must include an	01710		

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01710	Continued From page 31 identification and review of all medications the resident is known to be taking. The assessment must include indications for use, side effects, contraindications, allergic and adverse reactions, and actions to address these issues. The assessment must identify interventions needed in management of medications to prevent diversion. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

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01730	Continued From page 32 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on July 10, 2023, at 9:59 a.m., clinical nurse supervisor (CNS)-B	01730		

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01730	Continued From page 33 stated the licensee provided medication management services to residents at the facility. R1 R1's diagnoses included diabetes, depression, and history of alcohol abuse. R1's service plan dated December 29, 2022, indicated the resident received services which included medication setup and medication administration. R1's prescriber orders dated July 26, 2022, August 31, 2022, March 1, 2023, and April 17, 2023, included one mild pain reliever, one antihypertensive medication, two diuretics, one medication to treat heart burn, two antidepressants, one medication to treat nerve pain, one long-acting insulin, one oral and one injectable antidiabetic medication, one medication to treat urinary retention, one medication to treat high cholesterol, and one antihistamine. On July 10, 2023, at 2:51 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled afternoon medication. R1's Individualized Medication Management Plan dated December 23, 2022, did not include documentation medication reconciliation had been completed. R2 R2's diagnoses included congested heart failure (CHF- condition in which the heart's function as a pump is inadequate to meet the body's needs), hypertension (HTN- high blood pressure), muscle weakness, and atrial fibrillation (irregular often fast heart rate).	01730		

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01730	Continued From page 34 R2's service plan dated April 12, 2023, indicated the resident received services which included medication setup and medication administration. R2's prescriber orders dated April 20, 2023, April 25, 2023, and April 26, 2023, included one bladder relaxant medication, one diuretic, one blood thinner, two antihypertensives, one medication to treat heart rhythm irregularities, one medication to treat heart burn, and two vitamin/mineral supplements. On July 11, 2023, at 8:10 a.m., the surveyor observed ULP-G administer R2's scheduled morning medications. R2's Individualized Medication Management Plan dated April 12, 2023, did not include documentation medication reconciliation had been completed. On July 11, 2023, at 1:36 p.m., CNS-B stated R1 and R2's medication management plans did not include medication reconciliation. CNS-B stated this would be the same for all residents at the facility who received medication management services. The licensee's Medication Management Individualized Plan policy dated August 1, 2021, noted the facility would develop and maintain a current individualized medication management record for each resident based on the resident's assessment. Medication reconciliation would be completed when a licensed nurse, licensed health professional, or authorized prescriber was providing medication management. No further information was provided.	01730		

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01730	Continued From page 35 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of four unlicensed personnel (ULP-D); failed to ensure medications were administered as ordered for one of four residents (R7); and failed to ensure insulin was administered per the manufacturer's instructions for one of one resident (R1) whom received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number	01760		

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01760	Continued From page 36 of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MEDICATION ADMINISTRATION PROCESS - SIGNING OFF MEDICATIONS PRIOR TO ADMINISTRATION Medication for R5 was documented by ULP-D as being administered prior to the medication being administered. On July 10, 2023, at 1:56 p.m., the surveyor observed ULP-D administer R5's scheduled afternoon medication. The following was observed: - ULP-D washed her hands and put on gloves - ULP-D removed from a preset medication planner R5's scheduled gabapentin (medication to treat nerve pain) 100 milligrams (mg) - ULP-D placed the gabapentin into a medication cup - ULP-D checked the medication administration record (MAR) and initialed R5's MAR by the medication she had checked indicating the medication had been administered - ULP-D brought the medication to R5 who was seated in a recliner - ULP-D took the medication with a sip of water On July 10, 2023, at 2:00 p.m., immediately following the above observation, ULP-D stated she had signed off R5's gabapentin prior to R5 taking the medication. ULP-D stated it was her usual routine to sign off the medications when she checked the MAR. On July 11, 2023, at 1:14 p.m., clinical nurse	01760		

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01760	Continued From page 37 supervisor (CNS)-B stated the staff have been instructed when administering medications to sign off the medications after the resident had taken the medication. The licensee's Medication Management - Administration and Setup policy dated August 1, 2021, noted documentation of a medication reminder, medication assistance or medication administration would be completed immediately after the task had been performed. TRANSCRIPTION ERROR R7's diagnoses included glaucoma, osteoarthritis, and leg weakness. R7's prescriber orders dated June 6, 2023, included an order for dorzolamide hydrochloride/timolol maleate ophthalmic solution 22.3-6.8 mg/milliliter (ml) (glaucoma medication) instill one drop into each eye twice daily. On July 11, 2023, at 8:32 a.m., the surveyor observed ULP-H to prepare to administer R7's scheduled morning eye drops. The following was observed: - ULP-H removed from R7's locked medication drawer in R7's apartment R7's July 1, 2023, through July 15, 2023, MAR - ULP-H removed from R7's medication drawer the only bottle of eye drop solution in the drawer which was labeled maleate ophthalmic solution 22.3-6.8 mg/ml - ULP-H checked R7's MAR and stated R7's MAR had two eye drops listed refresh eye drops and Combigan Suspension 1% - ULP-H stated she knew the refresh eye drops had just ran out and the family was bringing another bottle in - ULP-H stated she needed to notify the nurse	01760		

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01760	Continued From page 38 because the Combigan Suspension 1% eye drops were not in R7's drawer and she couldn't see on the MAR where the maleate eye drops were to be given R7's July 1, 2023, through July 10, 2023, MAR indicated Combigan Suspension 1% eye drops had been administered on July 1, 2, 3, 6, 7, 8, and 9, 2023; and a note written on July 4, 2023, that the eye drops had not been administered because they were not in the medication drawer. On July 11, 2023, at 8:45 a.m., CNS-B reviewed R7's July 2023, MAR. CNS-B instructed ULP-H to hold off on giving any of the eye drops until she could clarify the prescriber's order. On July 11, 2023, at 1:51 p.m., CNS-B stated through her investigation regarding R7's eye drops she determined the resident had been given the correct eye drop solution, however, there had been a transcription error. CNS-B stated she verified with the pharmacy and reviewed the prescriber orders. CNS-B stated R7 had never been prescribed Combigan suspension 1% eye drops only the maleate ophthalmic solution. CNS-B stated Combigan suspension had incorrectly been transcribed on R7's MAR in place of the maleate eye drop solution. CNS-B stated she completed an incident report. FOLLOWING MANUFACTURE'S INSTRUCTIONS R1's diagnoses included diabetes, depression, and history of alcohol abuse. R1's Medication Assessment for Safety in Self Administration dated December 23, 2022, indicated R1 was deemed able to partially safely self-administer medications which included insulin	01760		

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POPLAR MEADOWS OF MCINTOSH	325 SCOTS AVENUE SE MCINTOSH, MN 56556

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01760	Continued From page 39 "after staff sets up". R1's service plan dated December 29, 2022, indicated the resident received services which included medication setup and medication administration. R1's prescriber orders dated March 1, 2023, included an order for Lantus 55 units to be administered every morning via insulin pen (a multiple dose pen shaped injector device used for insulin administration). On July 11, 2023, at 9:35 a.m., the surveyor observed ULP-H prepare R1's insulin pen. ULP-H washed her hands and donned a pair of gloves. ULP-H removed the cap of the Lantus insulin pen and wiped the diaphragm at the top of the pen with an alcohol wipe. ULP-H attached the needle to the pen and handed the Lantus insulin pen to R1. R1 dialed the pen to 55 units, which ULP-H verified. R1 proceeded to lift his shirt and injected the 55 units of Lantus insulin into his mid abdominal area. ULP-H was not observed to prime the insulin pen prior to having R1 dial up the prescribed Lantus insulin dose. On July 11, 2023, at 9:42 a.m., immediately following the above noted observation, ULP-H stated she had not primed R1's insulin pen prior to having him dial up the prescribed dose. ULP-H stated she was aware the insulin pen should have been primed with two units. On July 11, 2023, at 1:16 p.m., CNS-B stated the staff should prime R1's Lantus insulin pen prior to having him dial up the prescribed 55 units. The undated instruction sheet in R1's medication drawer noted "when getting [name of resident] insulin pen ready, use an alcohol wipe and wipe the end of the pen where the needle with [sic] go.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30294	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR MEADOWS OF MCINTOSH	325 SCOTS AVENUE SE MCINTOSH, MN 56556

(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
01760	Continued From page 40 Then put needle on. You then need to prime the pen. This means turn the dial to 2 and press then inject button into air. Watch for liquid coming out of the pen. This is to make sure the pen is working. This must be done every time you give the insulin." The manufacturer's instructions for the use of Lantus insulin pens, dated May 2019, directed for the insulin pen to be primed with two units prior to dialing up the prescribed dosage. The licensee's Injections-Subcutaneous policy dated August 1, 2021, directed for staff to prime the insulin pen per manufacturer instructions to remove any air bubbles that may be present. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R1, R2).	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30294	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR MEADOWS OF MCINTOSH	325 SCOTS AVENUE SE MCINTOSH, MN 56556

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01770	Continued From page 41 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: R1 R1's diagnoses included diabetes, depression, and history of alcohol abuse. R1's service plan dated December 29, 2022, indicated the resident received services which included medication setup and medication administration. R1's prescriber orders dated July 26, 2022, August 31, 2022, March 1, 2023, and April 17, 2023, included one mild pain reliever, one antihypertensive medication, two diuretics, one medication to treat heart burn, two antidepressants, one medication to treat nerve pain, one long-acting insulin, one oral and one injectable antidiabetic medication, one medication to treat urinary retention, one medication to treat high cholesterol, and one antihistamine. On July 10, 2023, at 2:51 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled afternoon medication from a preset medication planner (a plastic medication box with designated compartments for days and times). R1's medication administration record (MAR) dated July 1, 2023, through July 15, 2023, had a row after each oral medication with a box for each	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30294	A. BUILDING: _____ B. WING _____	07/12/2023

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POPLAR MEADOWS OF MCINTOSH	325 SCOTS AVENUE SE MCINTOSH, MN 56556

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01770	Continued From page 42 date to document "med setup". The row to document medication setup was blank. R1's records lacked documentation by the licensed nurse at the time of medication setup to include documentation of the dates of medication setup, the name of the medication, quantity of dose, and times to be administered, and route of administration and name of person completing medication setup. On July 12, 2023, at 9:00 a.m., clinical nurse supervisor (CNS)-B stated she had setup R1's oral medications on July 3, 2023, for seven days and had not documented the medication setup. R2 R2's diagnoses included congested heart failure (CHF- condition in which the heart's function as a pump is inadequate to meet the body's needs), hypertension (HTN- high blood pressure), muscle weakness, and atrial fibrillation (irregular often fast heart rate). R2's service plan dated April 12, 2023, indicated the resident received services which included medication setup and medication administration. R2's prescriber orders dated April 20, 2023, April 25, 2023, and April 26, 2023, included one bladder relaxant medication, one diuretic, one blood thinner, two antihypertensives, one medication to treat heart rhythm irregularities, one medication to treat heart burn, and two vitamin/mineral supplements. On July 11, 2023, at 8:10 a.m., the surveyor observed ULP-G administer R2's scheduled morning medications from a preset medication planner.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30294	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR MEADOWS OF MCINTOSH	325 SCOTS AVENUE SE MCINTOSH, MN 56556

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01770	Continued From page 43 R2's MAR dated June 16, 2023, through July 15, 2023, had a row after each oral medication with a box for each date to document "med setup". The following dates had CNS-B's initials indicating she had set up medications for that specific day: June 20, 2023, June 26, 2023, and July 3, 2023. R2's records lacked documentation by the licensed nurse at the time of medication setup to include documentation of the dates of medication setup. On July 11, 2023, at 1:39 p.m., CNS-B stated she only documented medication setup for the day she set up the resident's medications and does not indicate on the MAR how many days of medication have been setup for each medication. The licensee's Medication Management-Dosage Box Setup policy dated August 1, 2021, noted a licensed nurse will assure the medication orders are transcribed onto the MAR. This profile includes dates of medication setup, medication name, quantity of dose, times to be administered, route of administration, and name of person completing the medication setup. When the licensed nurse has completed setting up the medications into the dosage box, the setup is documented on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training	02140		

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	30294	A. BUILDING: _____ B. WING _____	07/12/2023

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02140	Continued From page 44 must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person overseeing staff training in the care of individuals with dementia (clinical nurse supervisor (CNS)-B), had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents and staff of 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility currently held an Assisted Living with Dementia Care (ALDC) license. During the entrance conference on July 10, 2023, at 9:32 a.m., licensed assisted living director (LALD)-A stated the facility currently did not have anyone certified to oversee the dementia care	02140		

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02140	Continued From page 45 training for staff. LALD-A stated the plan was for CNS-B to complete the required training and certification. CNS-B stated she had over two years of work experience in long term care, however, had not yet completed the required training nor had obtained the certification as required. The licensee's ALDC Additional Dementia Staff Training policy dated August 1, 2021, noted persons conducting dementia care training would be qualified to train in the care of individuals with dementia. Qualifications included two years or work experience related to Alzheimer's disease or other dementias, or in the healthcare, gerontology, or another related field, and; have completed and passed training approved by the Minnesota Department of Health (MDH). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02140		

DEPARTMENT OF HEALTH

Type: Full
Date: *07/10/23*
Time: 10:51:28
Report: 8045231086

Food and Beverage Establishment Inspection Report

Location:

Poplar Meadows Of Mcintosh
325 Scots Avenue Se
McIntosh, MN56556
Polk County, 60

Establishment Info:

ID #: 0037670
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185632436
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.

2-300 Personal Cleanliness

2-301.14A ***** Priority 1 *****

MN Rule 4626.0075A Food employees must wash their hands before: food preparation activities, including working with exposed food; touching clean equipment and utensils; touching unwrapped single-service and single-use articles.

OBSERVED FACILITY STAFF ENTER KITCHEN WEARING GLOVES AND DIRECTLY BEGIN TO HANDLE PLATE COVERS.

Corrected on Site

4-200 Equipment Design and Construction

4-204.115 ***** Priority 2 *****

MN Rule 4626.0635 Provide a temperature measuring device in the warewashing machine that indicates the temperature of the water in the wash tank, rinse tank, and the water that enters the sanitizing final rinse manifold or the chemical sanitizing solution tank.

TEMPERATURE MEASURING DEVICE FOR THE RINSE TANK AND MANIFOLD NOT OPERATIONAL AT TIME OF INSPECTION.

Comply By: 07/24/23

Surface and Equipment Sanitizers

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

Hot Water: = at 164 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Type: Full
Date: *07/10/23*
Time: 10:51:28
Report: 8045231086
Poplar Meadows Of Mcintosh

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: HAM (AA)
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: RIBS (AA)
Violation Issued: No

Process/Item: Hot Holding
Temperature: 175 Degrees Fahrenheit - Location: LIVER
Violation Issued: No

Process/Item: Cooking
Temperature: 180 Degrees Fahrenheit - Location: CHICKEN BREAST
Violation Issued: No

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

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

I acknowledge receipt of the inspection report number 8045231086 of 07/10/23.

Certified Food Protection Manager: RHONDA L. LARSON

Certification Number: FM88898 Expires: 04/30/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Adam J. Bommersbach
Adam Bommersbach
Public Health Sanitarian
705 5th Street NW, Suite A
(218) 308-21
adam.bommersbach@state.mn.us