Electronically Delivered

February 2, 2022

Administrator
Valentines Assisted Living LLC
2557 Eagle Ridge Drive
Red Wing, MN 55066

RE: Project Number(s) SL30583015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 6, 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

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

DOCUMENTATION OF ACTION TO COMPLY
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 surveys. 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 addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

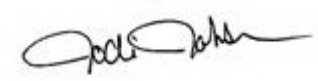
REQUESTING A HEARING

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,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 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
	30583	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALENTINES ASSISTED LIVING LLC	2557 EAGLE RIDGE DRIVE RED WING, MN 55066

(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: SL#30583015 On January 4, 2022, through January 6, 2021, 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 16 residents receiving services under the provider's Assisted Living license. The immediate correction order tag identification 0110, identified on January 4, 2022, has been corrected as of January 5, 2022. No further action required.	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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure licensed assisted living director (LALD-A) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This resulted in an immediate correction order on January 4, 2022, at 2:15 p.m. 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: LALD-A started employment on December 1, 2007, under the licensee's comprehensive home care license and began providing assisted living services on August 1, 2021. On January 4, 2022, at approximately 8:53 a.m. upon entrance to the facility, the LALD license was posted in a wood and glass cabinet hanging on a wall inside of the main entrance of the facility. On January 4, 2022, at approximately 9:20 a.m. during the entrance conference, LALD-A stated	0 110		

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0 110	Continued From page 2 the posted LALD was the previous owner's LALD license. LALD-A stated her LALD license was at the office located at another assisted living facility, which she owned. LALD-A stated the previous owner was no longer involved with either facility as of December 1, 2021. On January 4, 2022, at approximately 1:56 p.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license, but LALD-A was not listed as the Director of Record for any licensee, and was not listed as a shared director. On January 4, 2022, at approximately 2:15 p.m. LALD-A stated the previous owner was not a current employee of the licensee. The licensee policy Assisted Living Director dated August 1, 2021, indicated the company expected the licensed or permitted director to comply with all requirements set forth by Board of Executives for Long Term Services and Supports (BELTSS) as a licensed professional to remain in good standing. No further information was provided Time Period for Correction: IMMEDIATE On January 5, 2022, at 8:35 a.m. immediacy was removed as confirmed by email correspondence with evaluation supervisor. At 8:38 a.m., LALD-A was informed in person by surveyor of the immediacy being removed.	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 3 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the 24-hour staffing schedule was posted 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	0 470		

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0 470	Continued From page 4 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: 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 -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 On January 4, 2021, at 9:03 a.m. a white board had written "staff on" with unlicensed personnel (ULP)-C and ULP-F's first names. In a display case there was a fixed "Monthly Staffing Schedule Plan" posted with weeks one through six, shifts listed for a.m. (two for 6 a.m. to 2 p.m.); p.m. (one for 2 p.m. to 10 p.m. and one for 5 p.m. to 9 p.m.); and noc (night) (one for 10 p.m. to 6 a.m.) for every week, and the word "caregiver" listed for each shift position for each day of the month. The Monthly Staffing Schedule Plan further indicated "nurse on call 24/7. All staff assigned to all residents" and "no specific assignments unless otherwise directed." There was no other posted staff schedule observed in any area of the facility. On January 4, 2022, at 11:49 a.m. licensed	0 470		

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0 470	Continued From page 5 assisted living director (LALD)-A verified the the licensee lacked posted daily staffing schedule after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. The licensee policy Staffing and Scheduling dated August 1, 2021, indicated the clinical nurse supervisor would develop a 24 hour daily staffing schedule that would identify direct care staff work schedules for each direct care staff member showing all work shifts, including days and hours worked and the direct care staff resident assignments or work location. The policy further indicated 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (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:	0 480		

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0 480	Continued From page 6 (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 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 6, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents:	0 485		

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0 485	Continued From page 7 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu prepared in advance included all meals and snacks. This had the potential to affect all 16 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 485		

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0 485	Continued From page 8 The licensee menu lacked inclusion of the breakfast meal and snacks. On January 4, 2022, at 8:53 a.m. a display case (on the wall to the right of the front door upon entering) had a posted menu for the week of January 3 - 9, 2022. The menu included "Dinner" and "Supper" meals for each day of the week. The menu lacked breakfast meals and snacks for the week. On January 4, 2022, at 11:08 a.m. certified food protection manager (CFPM)-E verified the menu posted for the week of January 3 - 9, 2022, did not include breakfast or snacks. CFPM-E stated breakfast was not posted on the menu due to breakfast was "made to order." CFPM-E stated snacks were "always available" and a snack was served to residents between 2 p.m. and 3 p.m. every day. CFPM-E stated she verbally informed the residents what was available for breakfast when the resident came to the dinning room to eat. The licensee policy Food Service and Menu Planning dated August 1, 2021, indicated the company will offer to provide or make available at least three meals daily with snacks available seven days per week and menus would be prepared at least one week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 9 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an effective infection control program to comply with current recommendations for COVID-19. 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), 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: SCREENING VISITORS The licensee lacked documented screening of visitors for COVID-19 as recommended. On January 4, 2022, at 8:53 a.m. upon entrance to the facility, a Visitor Log and Contact Tracing	0 510		

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0 510	Continued From page 10 Register and Visitor COVID-19 Screening Log (all visitors upon entry, sign in, take and record their temperature, sanitize their hands and confirm that they have not been in contact with anyone sick with COVID-19 in the past 14 days and that they are healthy.) "By signing this, I attest that I have no respiratory symptoms including fever, cough with shortness of breath, fever (temp greater than 100 degrees Fahrenheit or feeling feverish), sore throat, muscle pain, headache, chills, new loss of taste or smell." There was a thermometer for visitors to check their temperature, and hand sanitizer available for visitors to sanitize their hands. The Visitor Log and Contact Tracing Register included documented date, full name, reason for visit, time in, time out and signature. The log lacked an area to document temperature as per the licensee Visitor COVID-19 Screening Log indicated to do; lacked screening for symptoms as indicated from the Centers for Disease Control and Prevention (CDC) webpage titled "Symptoms of COVID-19" updated February 22, 2021, and lacked screening for recommendations as indicated on the CDC guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated Sept. 10, 2021. SCREENING EMPLOYEES The licensee lacked documented screening of employees for COVID-19 as recommended. On January 5, 2022, at 10:06 a.m. unlicensed personnel (ULP)-G and ULP-H stated employees self-screened and documented on the paper tablet their name, the date, temperature and initials upon entrance to the facility for work.	0 510		

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	30583	A. BUILDING: _____ B. WING _____	01/06/2022

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VALENTINES ASSISTED LIVING LLC	2557 EAGLE RIDGE DRIVE RED WING, MN 55066

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0 510	Continued From page 11 ULP-G and ULP-H stated they do not document any response for symptoms, but there was a list of symptoms on the paper tablet to watch for. The paper tablet had a Staff COVID-19 Screening Log, which indicated all staff upon entry, sign in, take and record their temperature, sanitize their hands and confirm that they have not been in contact with anyone sick with COVID-19 in the past 14 days, and that they were healthy. "By signing this, I attest that I have no respiratory symptoms including fever, cough with shortness of breath, fever (temp greater than 100 degrees Fahrenheit or feeling feverish), sore throat, muscle pain, headache, chills, new loss of taste or smell." The log lacked screening for symptoms as indicated from the Centers for Disease Control and Prevention (CDC) webpage titled "Symptoms of COVID-19" updated February 22, 2021, and lacked screening for recommendations as indicated on the CDC guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated Sept. 10, 2021. On January 5, 2022, at 12:44 p.m. licensed assisted living director (LALD-A) verified temperatures were not being documented by visitors and verified the above for what the licensee was currently conducting for screening of visitors and employees. EYE PROTECTION The licensee failed to ensure employees wore eye protection. On January 4, 2022, at 12:40 p.m. ULP-F, ULP-C	0 510		

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0 510	Continued From page 12 and certified food protection manager (CFPM)-E were in the dining room area with residents and were not wearing eye protection. COMPETENCY EVALUATION ULP-D had a hire date of September 17, 2021. ULP-D's employee record lacked documented competency evaluation for putting on and removal of personnel protective equipment (PPE) for COVID-19. On January 6, 2022, at 2:23 p.m. LALD-A stated staff should be wearing eye protection. The Centers for Disease Control and Prevention (CDC) webpage titled "Symptoms of COVID-19" updated February 22, 2021, indicated "People with COVID-19 have had a wide range of symptoms reported ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. People with these symptoms may have COVID-19: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea, This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19. Older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from COVID-19 illness". The CDC guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus	0 510		

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0 510	Continued From page 13 Disease 2019 (COVID-19) Pandemic updated Sept. 10, 2021, indicated ensure everyone is aware of recommended IPC practices in the facility. Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for quarantine or exclusion from work. Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility. Implement Universal Use of Personal Protective Equipment for HCP If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: Facilities could consider use of NIOSH-approved N95 or equivalent or higher-level respirators for HCP working in other situations where multiple risk factors for transmission are present. One example might be if the patient is unvaccinated, unable to use source control, and the area is poorly ventilated. Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. The Minnesota Department of Health (MDH) guidance titled, COVID-19 Guidance: Long-term Care Indoor Visitation for Nursing Facilities and Assisted Living Settings, updated December 29, 2021, indicated this guidance replaces previous Minnesota Department of Health (MDH) visitation guidance for Minnesota's long-term care settings, such as nursing facilities, skilled nursing facilities,	0 510		

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0 510	Continued From page 14 and assisted living facilities. The following core principles of COVID-19 infection prevention are consistent with Centers for Disease Control and Prevention (CDC) guidance and should be adhered to at all times. Refer to #1 on the CMS FAQ. Per CMS QSO 20-39, core principles include: Visitors who have a positive viral test for COVID-19; symptoms of COVID-19; or currently meet the criteria for quarantine, should not enter the facility. Facilities should screen all who enter for these visitation exclusions. Having staff wear face masks and other needed personal protective equipment. The licensee policy COVID-19 Preparedness Plan dated March 27, 2020, indicated for precautions to take included, but not limited to, implement active screening of caregivers for fever and respiratory symptoms, staff should wear a surgical mask and eye protection during shift and reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of personal protective equipment. Have caregivers demonstrate competency with putting on and removing PPE. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 680		

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0 680	Continued From page 15 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure emergency exit diagrams were posted, failed to develop an all-hazards emergency preparedness (EP) program and plan to include Appendix Z required elements. This had the potential to affect all 16 residents in the facility, staff and any 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	0 680		

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0 680	Continued From page 16 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: EMERGENCY EXIT DIAGRAM The licensee lacked posted emergency exit diagrams in the facility. On January 4, 2022, at 11:08 a.m. no posted emergency exit diagrams were observed in any area of the facility (outside of residents' rooms), which was verified by licensed assisted living director (LALD)-A. TRAINING ULP-D had a hire date of September 17, 2021. ULP-D's employee record lacked evidence of emergency and disaster training. On January 5, 2022, at 12:44 p.m. LALD-A verified ULP-D lacked emergency and disaster training. EMERGENCY PREPAREDNESS PLAN On January 4, 2022, at 11:08 a.m. the licensee's Disaster and Communication Plan reviewed December 1, 2021, was observed to be in a binder, which was inside of a decorative tin bucket located on a ledge by the front entrance in the main lobby sitting area. On January 5, 2022, at 1:54 p.m. LALD-A and office manager (OM)-B were interviewed regarding the licensee's Disaster and Communication Plan. LALD-A and OM-B confirmed the licensee lacked the following: - written documentation of a risk assessment; - identification of at risk population needs like	0 680		

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0 680	Continued From page 17 maintaining independence, communication, transportation, supervision, medical care; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure addressing alternate sources of energy to maintain (temperatures to protect resident health/safety, safe and sanitary storage of provisions) and sewage and waste disposal; - policy and procedure for volunteers; - policy and procedure to address role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - emergency officials contact information (Federal); - communication plan which includes means to providing information about the facility occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; - development of EP training and testing; - a training program which included initial training in EP policy and procedure to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected roles, provide EP training annually, maintain documentation of all EP training; and - emergency prep testing requirements (conduct exercises to test EP twice per year, including unannounced staff drills using the EP (which includes conducting annual full scale exercise that is community based/facility based functional exercise/or if facility experiences an actual emergency requiring actual activation of plan, facility is exempt from engaging in its next required full scale exercise), conduct an additional annual exercise (which may include a second full scale community based, facility based functional exercise or mock disaster drill or table	0 680		

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0 680	Continued From page 18 top exercise) and analyze the facility's response to and maintain documentation of drills, table top exercises and emergency events and revise plans as needed. The licensee policy Emergency Preparedness dated August 1, 2021, indicated the intent of the company was to have in place an effective and compliant EP plan. The intent of the plan would be aligned with Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z-Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance." The company's EP plan would include all required elements of appendix Z. The plan would be based on our assisted living based and community based risk assessments, utilizing an all-hazards approach. Key elements of the plan would include four primary components: risk assessment and planning, policies and procedures, a communication plan, staff training and exercises/drills. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code,	0 790		

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0 790	Continued From page 19 located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interviews the facility failed to ensure installation and maintenance of portable fire extinguishers on-site. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the building tour on January 05, 2022, with licensed assisted living director (LALD)-A and office manager (OM)-B, the surveyor observed the inspection tag on the fire extinguisher was past due. The inspection had not been done in more than 12 months. LALD-A confirmed fire extinguishers had not been inspected due to labor shortages at the third-party inspection company they contract. The assisted living facility had no inspection records for portable fire extinguishers. No further information was provided.	0 790		

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0 790	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
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.	0 810		

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0 810	Continued From page 21 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to identify unique or unusual resident needs for movement or evacuation, failed to provide required training to residents and employees for fire safety and evacuation. This had the potential to affect all current residents, staff, and visitors to 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: On January 05, 2022, at approximately 12:00 p.m. the surveyor requested to review the licensee's fire safety and evacuation policy, plans, procedures, schedules, and logs, if available. Upon review the following items were not documented: 1. No written instructions for addressing any unique situation during evacuation especially for residents who are wheelchair-bound and need assistance during an evacuation. 2. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation.	0 810		

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0 810	Continued From page 22 3. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. Licensed assisted living director (LALD)-A and office manager (OM)-B confirmed documentation of fire safety and evacuation policy and procedures were incomplete. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01420		

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01420	Continued From page 23	01420		

review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for two of two unlicensed personnel (ULP-C, ULP-D) who performed delegated tasks.

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 January 5, 2022, at 9:59 a.m., R5 was observed to be seated in a BRODA chair (medical equipment used when sitting to reduce pressure and maintain mobility) in her room. ULP-G was present and verified staff transfer R2 in and out of the BRODA chair utilizing a Hoyer lift (full body mechanical lit).

ULP-C had a hire date of November 7, 2019.

ULP-D had a hire date of September 17, 2021.

ULP-C and ULP-D's employee records lacked documentation for training and competency evaluation for BRODA chair use.

On January 5, 2022, at 12:44 p.m. licensed assisted living director (LALD)-A stated, "No" in response to the licensee's ULP having been trained and competency evaluated for the use of a BRODA chair.

The licensee policy Competency and Training

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01420	Continued From page 24 dated August 1, 2021, indicated when a RN of the company delegated tasks, prior to the delegation of services they "must" make certain the ULP was trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to completely follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and	01650		

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01650	Continued From page 25 (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 On January 5, 2022, at 7:24 a.m. R1 was observed to be seated in a chair in the living room area watching television. R1's Assisted Living Service Plan dated December 1, 2021, lacked the following: -the schedule and methods of monitoring assessments of the resident; -a contingency plan that included: -the action to be taken if the scheduled service cannot be provided; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including	01650		

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01650	Continued From page 26 identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters R1's service plan indicated code status was "do not intubate/do not resuscitate," but it did not indicate if R1 had advance directives (living will). The contingency plan indicated "if services are needed for medical or safety reasons and facility staff are unable to keep the service, we will make arrangements for services to be provided through an outside provider or other means, which may include your transfer to another facility, agency, and or acute care setting"; however, the contingency plan did not indicate who the "outside provider or other means" would be. The "designated representative" area of the service plan indicated "emergency contact listed below may be contacted if there is a significant adverse change in my condition. This person also has the authority to sign for me if I am unable to do so or in the case of an emergency"; however, no emergency contact name or contact information for a person was listed. R2 On January 5, 2022, at 7:25 a.m. R2 was observed laying in bed. At 8:08 a.m., R2 stated she had compression socks on both lower legs "to knee," which the licensee staff put on and took off. R2's Physician Service Order dated December 2, 2021, indicated bilateral knee high compression stockings on during the day and off at night.	01650		

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01650	Continued From page 27 R2's Individualized Treatment or Therapy Management Plan dated December 1, 2021, indicated the service provided was "compression garments". R2's Service Recap Summary Month dated December 2021, identified the licensee staff documented for providing "compression socks" for the time of "AM" and "Bedtime" daily. R2's Assisted Living Service Plan dated December 1, 2021, lacked the following: -a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences (lacked treatment of compression stockings knee-high) -the schedule and methods of monitoring assessments of the resident -a contingency plan that included: -the action to be taken if the scheduled service cannot be provided; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2's service plan indicated code status was "do not intubate/do not resuscitate," but it did not indicate if R2 had advance directives (living will). The contingency plan indicated "if services are needed for medical or safety reasons and facility staff are unable to keep the service, we will make	01650		

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01650	Continued From page 28	01650		

arrangements for services to be provided through an outside provider or other means, which may include your transfer to another facility, agency, and or acute care setting"; however, the contigency plan did not indicate who the "outside provider or other means" would be. The "designated representative" area of the service plan indicated "emergency contact listed below may be contacted if there is a significant adverse change in my condition. This person also has the authority to sign for me if I am unable to do so or in the case of an emergency"; however, no emergency contact name or contact information for a person was listed.

On January 6, 2022, at 12:36 p.m. licensed assisted living director (LALD)-A stated she had "made new service plans" and "missed" addressing the schedule and methods of monitoring assessments of the resident. LALD-A verified all of the information above, and further indicated all resident service plans would lack the same information.

The licensee policy Service Plan dated August 1, 2021, indicated all residents receiving services would have a service plan in place and the service plan would include the above content required. The policy had an attached "service plan sample form". The form indicated all monitoring, reassessment, and supervision of a resident will be done by a licensed nurse, method of monitoring reviews or assessments would be noted on the monitoring and reassessment form as to whether it was completed in person or by telecommunication needed and contingency plan area indicated "describe service and action plan here" for addressing how services would be provided if the licensee could not provide

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01650	Continued From page 29 services. The form also indicated "living will" would be addressed for "health care directive". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=D	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 medication was administered as ordered for one of three residents (R4) observed for medication administration, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01760		

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01760	Continued From page 30 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee lacked administration of the medication Senna-S (used to treat constipation) as prescribed. R4's MD (doctor of medicine) Orders dated November 9, 2021, included, but not limited to, orders for the medications of isosorb monitrate (used to prevent chest pain) 30 milligrams (mg) one half tablet daily, levetiracetam (used to control seizures) 750 mg twice daily, metoprolol (used to treat high blood pressure) 50 mg one half tablet daily, potassium citrate (used to make urine less acid) 5 milliequivalents (meq) three times a day, Senna-S 8.6 mg one tablet twice daily and trospium (used to treat over active bladder) 20 mg one table twice daily. The orders identified the medications were to be administered at 8:00 a.m. On January 5, 2022, at 7:42 a.m. unlicensed personnel (ULP)-G was observed to administer medications to R4. ULP-G placed five pills from the 8 a.m. Wednesday compartment of a weekly pill box into a medication cup. ULP-G counted the pills at the time and stated there were "five" pills in the medication cup. ULP-G administered the medications to R4. ULP-G then documented on the computer her signature for the administration of the medications she had administered to R4. ULP-G stated she had signed for administration of "metoprolol, isosorb, potassium, levetiracetam, Senna-S and trospium". ULP-G stated, "Yes, six pills" she had signed for administration of to R4.	01760		

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01760	Continued From page 31 ULP-G stated, "I told you wrong" for the number of pills that she had placed in the medication cup. ULP-G stated, "They were all in there" regarding the six medications she documented her signature for administering to R4. At 7:50 a.m. observation of R4's weekly pill box with ULP-H identified there were five pills preset in the remaining 8 a.m. compartments of the pill box. R4's Med Recap sheets identified ULP-G signed for administration of the six medications for the time of 8:00 a.m. On January 5, 2022, at 8:49 a.m. licensed assisted living director (LALD)-A stated R4's Senna-S was missing from the 8 a.m. compartment of R4's weekly pill box. LALD-A stated R4's Senna-S was delivered last evening, and she had now placed the medication into R4's weekly pill box for the remaining 8 a.m. compartments for administration. LALD-A stated ULP-G had administered the missing Senna-S to R4, which was not in the weekly pill box at the time the surveyor observed ULP-G administer medications to R4. LALD-A stated there was "a note" alerting the Senna-S was not in R4's weekly pill box, but ULP-G had not seen the note. The licensee policy Medication Management Administration and Setup dated August 1, 2021, indicated the nursing staff and unlicensed personnel trained to provide medication administration would document any medication administration provided accurately in each resident record. ULP will verify medications are set up correctly in the dosage box before administration to the resident by use of the medication profile. If any question of medication accuracy in the dosage box arises, the unlicensed staff would contact the licensed nurse	01760		

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01760	Continued From page 32 and receive direct instructions on handling any changes at the time, while in direct contact with the nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	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 as required for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee failed to ensure documentation for	01770		

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01770	Continued From page 33 medication setup in a medication dosage box was completed accurately at the time of setup. R1 On January 4, 2022, at 11:49 a.m. licensed assisted living director (LALD)-A was observed to set up one week of medications into a weekly pill box for R1. At the time, LALD-A stated medication setup was for January 11, 2022, p.m. through January 18, 2022, a.m. Upon completion of the medication setup, LALD-A documented January 11, 2022, a.m. through January 18, 2022, p.m., instead of documenting for starting on January 11, 2022, p.m. through January 18, 2022 a.m. R2 On January 4, 2022, at 11:49 a.m. LALD-A was observed to set up one week of medications into a weekly pill box for R2. At the time, LALD-A stated medication setup was for January 11, 2022, p.m. through January 18, 2022 a.m. Upon completion of the medication setup, LALD-A documented January 11, 2022, a.m. through January 18, 2022, p.m. for all medications (except medications were there was no supply), instead of documenting for starting on January 11, 2022, p.m. through January 18, 2022, a.m. On January 6, 2022, at 12:36 p.m. LALD-A verified she had documented medication setup for R1 and R2 inaccurately. The licensee's policy Medication Management Dosage Box Setup dated August 1, 2021, indicated a licensed nurse would set up resident dosage boxes timely and accurately and when	01770		

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01770	Continued From page 34 the licensed nurse had completed setting up the medications into the dosage box, the setup was documented on a med set up visit sheet or on the electronic medication administration record (EMAR). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of one medication refrigerator. 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:	01880		

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01880	Continued From page 35 The licensee failed to monitor the temperature of a medication refrigerator to ensure medications were stored according to manufacturer's instructions. On January 5, 2022, at 7:58 a.m. the refrigerator in the medication room was observed with licensed assisted living director (LALD)-A. LALD-A confirmed the refrigerator temperature to be 32 degrees Fahrenheit (F) at the time and confirmed the refrigerator lacked daily monitoring of temperature. At 10:06 a.m., unlicensed personnel (ULP)-H stated the refrigerator temperature was "recorded once monthly" on a sheet of paper in the kitchen. The documented temperatures in the kitchen for the medication refrigerator was 34 degrees F on November 30, 2021, 36 degrees F on December 31, 2021, and 37 degrees F on January 1, 2022. The refrigerator contained one or more of the following medications: -unopened Lantus (long-acting insulin) pens; -lorazepam (antianxiety medication) oral liquid; -unopened lantanoprost (used to lower pressure inside the eye) eye drops; and -Lumigan (used to lower raised pressure in the eye) eye drops The manufacturer's instructions for Lantus insulin pens dated December 2019, indicated before opening store the insulin pens in the refrigerator (36 to 46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for lorazepam dated February 2021, indicated store the lorazepam at a cold temperature. Refrigerate at (36 to 46 degrees F) and protect from light. The manufacturer's instructions for lantanoprost	01880		

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01880	Continued From page 36 dated August 2011, indicated for storage: protect from light. Store unopened bottle(s) under refrigeration (36 to 46 degrees F). The manufacturer's instructions for Lumigan dated December 2015 d December 2019, indicated store your Lumigan eye drops in a cool place where the temperature stays below 25 degrees Celsius (C) (77 degrees F). The licensee's policy Medication Storage dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 37 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for one of two residents (R1) with records reviewed This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Assisted Living Service Plan dated December 1, 2021, included, but were not limited to, the following services: blood glucose checks and indwelling catheter by the unlicensed	01940		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 38 personnel (ULP). On January 5, 2022, at 7:20 a.m. ULP-H stated R1 was already dressed, she had changed R1's Foley catheter bag over to a catheter leg bag, and had checked R1's blood sugar. At 7:24 a.m., R1 was observed sitting in a living room chair watching television. R1's Individualized Treatment or Therapy Management Plan form dated November 30, 2021, indicated type of services to be provided were blood glucose monitoring and catheter care. The plan indicated resident specific requirements relating to documentation and instructions of the treatment and therapy received was found in the electronic health records/treatment administration record/service charting record. R1's Planned Services electronic record identified resident specific instructions for catheter care for providing peri care, check area catheter leaves body for pain, swelling, redness, drainage as blood or pus, but the instructions did not include changing the Foley catheter bag to a catheter leg bag, cleaning of the catheter bags, or instructions for when the nurse should be notified when a problem arises with the treatment service. In addition, the Planned Services electronic record identified resident specific instructions for blood glucose indicating if under 60, follow hypoglycemic protocol and listed the instructions to follow; however, the instructions did not include parameters for high blood sugar, or instructions for when the nurse should be notified when a problem arises with the treatment service. On January 6, 2022, at 12:36 p.m. licensed assisted living director (LALD)-A verified the ULP	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30583	A. BUILDING: _____ B. WING _____	01/06/2022

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VALENTINES ASSISTED LIVING LLC	2557 EAGLE RIDGE DRIVE RED WING, MN 55066

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01940	Continued From page 39 were providing catheter care and blood sugar checks for R1. LALD-A verified ULP were changing/cleaning catheter bags (Foley drainage bag/catheter leg bag). LALD-A verified R1's Individualized Treatment or Therapy Management Plan lacked the above specific instructions for catheter care and blood sugar checks. The licensee's policy Treatment and Therapy Management Plan dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which would contain documentation of specific resident instructions relating to the treatments or therapy administration and procedures for when to notify a registered nurse when a problem arises with treatment or therapy services. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:	01950		

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	30583	A. BUILDING: _____ B. WING _____	01/06/2022

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01950	Continued From page 40 (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Assisted Living Service Plan dated December 1, 2021, included, but was not limited to, blood glucose checks and indwelling catheter by the unlicensed personnel (ULP). On January 5, 2022, at 7:20 a.m. ULP-H stated R1 was already dressed, she had changed R1's Foley catheter bag over to a catheter leg bag, and	01950		

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01950	Continued From page 41 had checked R1's blood sugar. At 7:24 a.m., R1 was observed sitting in a living room chair watching television. R1's Individualized Treatment or Therapy Management Plan form dated November 30, 2021, indicated the type of services to be provided were 'blood glucose monitoring and catheter care.' The plan included resident specific requirements relating to documentation, and instructions of the treatment and therapy received was located in the electronic health records/treatment administration record/service charting record. R1's Planned Services electronic record identified resident specific instructions for catheter care for providing peri care: check area catheter leaves body for pain, swelling, redness, drainage as blood or pus; and identified resident specific instructions for blood glucose indicating: if under 60 follow hypoglycemic protocol, and listed the instructions to follow. R1's record lacked specific instructions for changing the Foley catheter bag to a catheter leg bag, cleaning of the catheter bags and instructions for parameters of high blood sugar. On January 6, 2022, at 12:36 p.m. licensed assisted living director (LALD)-A verified the ULP were providing catheter care and blood sugar checks for R1. LALD-A verified ULP were changing/cleaning catheter bags (Foley drainage bag/catheter leg bag). LALD-A verified R1's record lacked specific instructions for changing Foley catheter bag to a catheter leg bag, cleaning the catheter bags, and instructions for parameters of high blood sugar.	01950		

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01950	Continued From page 42 The licensee's policy Delegation of Assisted Living Services dated August 1, 2021, indicated when the registered nurse delegates tasks to the unlicensed personnel, that person would specify in writing specific instructions for each resident and document those instructions in the resident record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered with records reviewed. 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	02260		

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	30583	A. BUILDING: _____ B. WING _____	01/06/2022

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02260	Continued From page 43 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 5, 2022, at 1:18 p.m. licensed assisted living director (LALD)-A stated the licensee did not have the written disclosure to provide to residents, families or other persons who requested it. LALD-A stated when the regulations changed on August 1, 2021, she thought the licensee did not need to provide the disclosure anymore. LALD-A verified the licensee would provided services to persons with dementia. The licensee lacked a policy for the dementia notice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02260		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable	02310		

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	30583	A. BUILDING: _____ B. WING _____	01/06/2022

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02310	Continued From page 44 health care and medical, or nursing standards for one of one resident (R2) observed with bedrails with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 5, 2022, at 7:25 a.m. R2 was observed laying in her bed. R2's bed had a bedrail on the right side of the upper half of the bed, in the up position. R2's Side Rail Use Assessment Form dated December 3, 2021, indicated the resident utilized the side rail to enable and promote independence. The assessment further indicated the positive and negative aspects of side rail use had been discussed with the resident and/or family, and the resident and/or responsible party were aware of the risks involved with side rail use; however, the assessment lacked documentation of measurements. On January 6, 2022, at 2:23 p.m. licensed assisted living director (LALD)-A was observed to measure R2's bedrail in the up position on the right upper half of R2's bed. The bedrail measurements were found to be within the FDA recommended dimensional measurements: between the rails measured between 2 to 3.5 inches and from the rail to the headboard	02310		

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02310	Continued From page 45 measured 3.5 inches. LALD-A verified R2's Side Rail Use Assessment Form lacked documentation of measurements. The licensee's policy Side Rails dated August 1, 2021, indicated when the company was aware a home care resident was utilizing side rails on a bed, the company would assess the use and verify that the side rails in use is of safe design and utilized consistent with manufacturer's directions. The policy further indicated staff would determine the side rail was safe as defined by meeting requirements, but not limited to, the side rail design was consistent with FDA's 2006 recommended dimensional measurements to reduce entrapment, meaning side rail zones 1, 2 and 3 must not exceed 4.75 inches. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails) and zone 3 (space between the rail and mattress), should be less than 4 and 3/4 inches. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information provided.	02310		

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02310	Continued From page 46 TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Division of Envrionmental Health, FPLS
PO BOX 64975
St Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/06/22*
Time: 13:30:00
Report: 8040221001

Food and Beverage Establishment Inspection Report

Location:
Valentines Assisted Living Llc
2557 Eagle Ridge Drive
Red Wing, MN55066
Goodhue County, 25

Establishment Info:
ID #: 0038599
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513881650
ID #:

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

The following orders were issued during this inspection.

3-200A Food Characteristics: approved source
3-201.11A ***** Priority 1 *****
MN Rule 4626.0130A Remove all foods not obtained from approved sources from the premises.
ROAST IN UPRIGHT FREEZER IN STORAGE ROOM NOT USDA OR MN EQUIVALENT STAMPED. REMOVE FROM FACILITY. MEAT PRODUCTS FROM LOCAL MEAT MARKET MUST BE USDA OR MN EQUIVALENT STAMPED.
Comply By: 01/06/22

4-200 Equipment Design and Construction
4-201.11AMN
MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
GLASS DOOR "PEPSI" COOLER IN STORAGE ROOM IS ONLY APPROVED FOR NON-TCS, BOTTLED OR PACKAGED PRODUCT ONLY. OBSERVED RAW EGGS, CHEESESTEAK PASTA, MILK, CHEESE AMONG OTHER ITEMS IN COOLER. PROVIDE AN UPRIGHT COOLER NSF/ANSI APPROVED FOR OPEN FOOD PRODUCT.
Comply By: 06/06/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: PRE-MIXED JUG
Violation Issued: No

Hot Water: = at 167 Degrees Fahrenheit
Location: DISHMACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: LEFTOVER BROCCOLI CHEESE SOUP
Violation Issued: No

Process/Item: Cooling
Temperature: 80 Degrees Fahrenheit - Location: CHICKEN PESTO PASTA -1.5HRS COOLING
Violation Issued: No

Process/Item: Cooling
Temperature: 58 Degrees Fahrenheit - Location: CHEESESTEAK PASTA - 2HRS COOLING
Violation Issued: No

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

INSPECTION CONDUCTED AS PART OF HRD ASSISTED LIVING SURVEY. DANETTE BAKKEN HRD NURSING EVALUATOR PRESENT DURING INSPECTION.

FACILITY STAFF ANDREA (RN/OWNER) AND PATRICIA, CFPM (E) PRESENT DURING INSPECTION.

THERMAL-LABELS PRESENT FOR HIGH TEMP DISHMACHINE. THIN-STEMMED THERMOMETER PROVIDED.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8040221001 of 01/06/22.

Certified Food Protection Manager: PATRICIA SEELEY

Certification Number: FM108947 Expires: 12/07/24

Signed: _____
ANDREA
RN/OWNER

Signed: _____
Matthew Finkenbiner
Sanitarian Supervisor
Rochester District Office
507-206-2744
matthew.finkenbiner@state.mn.us