DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 2, 2023

Licensee
President
1005 Milwaukee Street
Lakefield, MN 56150

RE: Project Number(s) SL23658015

Dear Licensee:

On July 31, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 31, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze

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

JMD

Electronically Delivered

July 5, 2023

Licensee
President
1005 Milwaukee Street
Lakefield, MN 56150

RE: Project Number(s) SL23658015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 31, 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23658	A. BUILDING: _____ B. WING _____	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDENT	1005 MILWAUKEE STREET LAKEFIELD, MN 56150

(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: SL23658015 On May 22, 2023, through May 26, 2023, and May 31, 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 19 active residents; all of whome were receiving services under the Assisted Living license. 2310: An immediate correction order was issued on May 24, 2023. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (l).	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.	
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety	0 640		

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0 640	Continued From page 1 through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on May 22, 2023, with licensed assisted living director (LALD)-A, there was no visible posting for information and phone	0 640		

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0 640	Continued From page 2 numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) or the 911 emergency number. LALD-A stated it was not posted but it should be. The licensee's 2.25 Report of Maltreatment of a Vulnerable Adult policy dated August 1, 2021, identified "The facility will support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: a. Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. b. Posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	0 660		

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0 660	Continued From page 3 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of two employees (unlicensed personnel (ULP)-C and 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). The findings include: ULP-C's personnel file identified she was hired on May 9, 2023. ULP-C had a TB screening and a first step TST administered on November 15, 2022, and a second step TST administered on November 25, 2022. This was greater than 90 days prior to ULP-C's hire. ULP-D's personnel file identified she was hired on January 3, 2022. ULP-D had a TB screening and	0 660		

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0 660	Continued From page 4 a first step TST administered on April 20, 2021, and a second TST administered on May 3, 2021. This was greater than 90 days prior to ULP-D's hire date. On May 25, 2023, at 1:00 p.m. licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated ULP-C had worked at the facility prior and she was rehired on May 25, 2023. Since the TB screening and testing was within the last year, LALD/LPN-A did not think it needed to be repeated. She was unaware previous testing had to be within 90 days. LALD/LPN-A stated ULP-D was transferred from another facility so she was unaware she needed to have TB screening and testing completed again. The licensee's 8.07 Tuberculosis & Staff Screening policy dated June 17, 2022, identified "Screening shall be conducted as follows: 1. New personnel, to include previous staff that are a rehire, shall be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New personnel, to include previous staff that are a rehire, shall have a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No team member shall be permitted to begin work where the work involves sharing the air space with home care clients until the negative results of the first Mantoux are read and documented." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a	0 660		

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0 660	Continued From page 5 negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	0 680		

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0 680	Continued From page 6 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 interview and record review, the licensee failed to conduct two full scale drills in the last year. This had the potential to affect all 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 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's Emergency Preparedness Plan contained no evidence the licensee had conducted two full scale drills annually. On May 25, 2023, at 2:50 p.m. licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated she was in charge of the emergency preparedness program. LALD/LPN-A stated the facility had not completed a full-scale drill in the last year. No additional information was provided.	0 680		

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0 680	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter	01060		

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01060	Continued From page 8 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation 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, 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 nurse notes dated August 30, 2022, identified R1 had fallen and was transported to the emergency room due to left hip pain. R1 was admitted to the hospital with a left femur fracture. R1's discharge summary dated December 20, 2022, identified R1 started receiving services on March 8, 2022. R1's services included medication administration, housekeeping, laundry, and	01060		

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01060	Continued From page 9 meals. R1 was transferred to the emergency room, was hospitalized, and then was transferred to a skilled nursing facility for rehabilitation. R1 discharged to the skilled nursing facility on December 20, 2022. R1's record failed to identify the resident, the resident's representative, and the resident's case manager had been provided, as soon as practicable, a written notice that contained: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On May 22, 2023, at 3:00 p.m. licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated they were unaware of the requirement at the time R1 was transferred to the emergency room. No additional information was provided.	01060		

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01060	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23658	A. BUILDING: _____ B. WING _____	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDENT	1005 MILWAUKEE STREET LAKEFIELD, MN 56150

(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
01370	Continued From page 11 family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-C and ULP-D) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C ULP-C was rehired on May 9, 2023, to provide direct care and services to residents under the assisted living licensure. On May 23, 2023, ULP-C was observed completing the following tasks: - at 7:15 a.m. ULP-C checked blood glucose on R3; - at 7:50 a.m. ULP-C administered oral medications to R7; - at 8:00 a.m. ULP-C administered oral medications and injectable medications to R3; and - at 9:07 a.m. ULP-C administered oral	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01370	Continued From page 12 medications and eye drops to R6 ULP-C's employee record lacked evidence of completed training and/or competency for the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01370	Continued From page 13 ULP-C's Minnesota Comprehensive Home Care Orientation and Requirements dated March 10, 2023, identified training that was to be completed by new employees, the last column for training identified to see the Educare training transcript. There were some education topics that were signed off by LALD/LPN-A; however, the transcript did not reflect the training had been completed, nor were the competencies signed off by the RN. ULP-C's Educare training transcript printed May 23, 2023, identified some training had been completed; however, the training did not include the above noted required training. On May 23, 2023, at 7:28 a.m. ULP-C stated licensed assisted living director/licensed practical nurse (LALD/LPN)-A had trained ULP-C which included training in medication administration, and LALD/LPN-A had observed and signed off on her administering medications prior to her administering them independently. ULP-D ULP-D was hired on January 3, 2022, to provide direct care and services to residents under the assisted living licensure. On May 23, 2023, ULP-D was observed completing the following tasks: - at 10:02 a.m. administered oral medications, eye drops, topical medications, and nasal spray to R4; and - at 1:02 p.m. checked blood glucose on R2. ULP-D's employee record lacked evidence of completed training and/or competency for the following:	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01370	Continued From page 14 - standby assistance techniques and how to perform them; ULP-D's Minnesota Comprehensive Home Care Orientation and Requirements was dated February 20, 2021, 11 months prior to ULP-D's hire date. ULP-D's Educare training transcript printed May 23, 2023, identified some training had been completed; however, the training did not include the above noted required training. On May 23, 2023, at 10:30 a.m. ULP-D stated she transferred from another facility owned by the same company. When she transferred, she followed another staff member for half a day and then was on her own. She did not have training and competencies completed at this facility; however, a RN had trained her at the other facility. On May 23, 2023, at 1:00 p.m. licensed assisted living director/ licensed practical nurse (LALD/LPN)-A stated the licensee had ULP's that were shared with another facility owned by the same company. The ULP were not competencied at each facility since it was the same company. She was unaware that competencies needed to be completed for each licensee. ULP-C transferred from another facility on March 9, 2023, and ULP-D transferred from another facility on January 3, 2022. LALD/LPN-A had completed the training with ULP-C and the RN was to complete the competencies. The Educare modules reflect what had been completed so if it was missing, then it was not done. She was unaware the staff were required to complete competentencies at both facilities.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01370	Continued From page 15 On May 25, 2023, at 1:20 p.m. clinical nurse supervisor (CNS)-B stated since the staff transferred from a different facility or were rehired, she was unaware competencies had to be completed for each licensee. The licensee's Competency Training Evaluations dated August 1, 2021, identified "Training and competency evaluations for all ULP will include: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the site c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional k) Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family l) awareness of confidentiality and privacy m) Understanding appropriate boundaries between team members, residents and	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01370	Continued From page 16 the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment & assistive devices." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-C and ULP-D) completed training and competency evaluations in all required training topics.	01380		

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01380	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C ULP-C was rehired on May 9, 2023, to provide direct care and services to residents under the assisted living licensure. On May 23, 2023, ULP-C was observed completing the following tasks: - at 7:15 a.m. ULP-C checked blood glucose on R3; - at 7:50 a.m. ULP-C administered oral medications to R7; - at 8:00 a.m. ULP-C administered oral medications and injectable medications to R3; and - at 9:07 a.m. ULP-C administered oral medications and eye drops to R6 ULP-C's employee record lacked evidence of completed training and/or competency for the following: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident;	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01380	Continued From page 18 (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. ULP-C's Minnesota Comprehensive Home Care Orientation and Requirements dated March 10, 2023, identified training that was to be completed by new employees, the last column for training identified to see the Educare training transcript. There were some education topics that were signed off by LALD/LPN-A; however, the transcript does not reflect the training had been completed, nor were the competencies signed of by the registered nurse (RN). ULP-C's Educare training transcript printed May 23, 2023, identified some training had been completed; however, the training did not include the above noted required training. On May 23, 2023, at 7:28 a.m. ULP-C stated LALD/LPN-A had trained her and signed off on her administering medications prior to her administering them independently. ULP-D ULP-D was hired on January 3, 2022, to provide direct care and services to residents under the assisted living licensure. On May 23, 2023, ULP-D was observed completing the following tasks: - at 10:02 a.m. administered oral medications, eye drops, topical medications, and nasal spray to R4; and - at 1:02 p.m. checked blood glucose on R2.	01380		

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01380	Continued From page 19 ULP-D's employee record lacked evidence of completed training and/or competency for the following: (3) reading and recording temperature, pulse, and respirations of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. ULP-D's Minnesota Comprehensive Home Care Orientation and Requirements was dated February 20, 2021, 11 months prior to ULP-D being hired by the licensee. ULP-D's Educare training transcript printed May 23, 2023, identified some training had been completed; however, the training did not include the above noted required training. On May 23, 2023, at 10:30 a.m. ULP-D stated she transferred from another facility owned by the same company. When she transferred, she followed another staff member for half a day and then was on her own. She did not have training and competencies completed at this facility; however, a RN had trained her at the other facility. On May 23, 2023, at 1:00 p.m. licensed assisted living director/ licensed practical nurse (LALD/LPN)-A stated the licensee had ULP's that were shared with another facility owned by the same company. The ULP were not competencied at each facility since it was the same company. She was unaware that competencies needed to be completed for each licensee. ULP-C transferred from another facility on March 9, 2023, and ULP-D transferred from another facility on January 3, 2022. LALD/LPN-A had completed	01380		

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01380	Continued From page 20 the training with ULP-C and the RN was to complete the competencies. The Educare modules reflect what had been completed so if it was missing, then it was not done. She was unaware the staff were required to complete competentencies at both facilities. On May 25, 2023, at 1:20 p.m. clinical nurse supervisor (CNS)-B stated since the staff transferred from a different facility or were rehired, she was unaware competencies had to be completed for each licensee. The licensee's Competency Training Evaluations dated August 1, 2021, identified "training and competency evaluation for ULP providing assisted living services must include: a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motion and positioning g. Administering medications or treatments as required" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01470	Continued From page 21	01470		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470		

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01470	Continued From page 22 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to include the required content for two of two employees (unlicensed personnel (ULP)-C and 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C ULP-C was rehired by the licensee on May 9, 2023, to provide direct care and services to	01470		

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01470	Continued From page 23 residents under the assisted living licensure. On May 23, 2023, ULP-C was observed completing the following tasks: - at 7:15 a.m. ULP-C checked blood glucose on R3; - at 7:50 a.m. ULP-C administered oral medications to R7; - at 8:00 a.m. ULP-C administered oral medications and injectable medications to R3; and - at 9:07 a.m. ULP-C administered oral medications and eye drops to R6 ULP-C's employee record lacked evidence of orientation for the following: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (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	01470		

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01470	Continued From page 24 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. ULP-C's Minnesota Comprehensive Home Care Orientation and Requirements dated March 10, 2023, identified training that was to be completed by new employees, the last column for training identified to see the Educare training transcript. There were some education topics that were signed off by licensed assisted living director/licensed practical nurse (LALD/LPN)-A; however, the transcript did not reflect the training had been completed. ULP-C's Educare training transcript printed May 23, 2023, identified some training had been completed; however, the training did not include the above noted required training. ULP-D ULP-D was hired on January 3, 2022, to provide direct care and services to residents under the assisted living licensure. On May 23, 2023, ULP-D was observed completing the following tasks: - at 10:02 a.m. administered oral medications, eye drops, topical medications, and nasal spray to R4; and - at 1:02 p.m. checked blood glucose on R2. ULP-D's employee record lacked evidence of completed training and/or competency for the following: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of	01470		

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PRESIDENT	1005 MILWAUKEE STREET LAKEFIELD, MN 56150

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01470	Continued From page 25 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); (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. ULP-D's Minnesota Comprehensive Home Care Orientation and Requirements was dated February 20, 2021, 11 months prior to ULP-D being hired by the licensee. ULP-D's Educare training transcript printed May 23, 2023, identified some training had been completed; however, the training on orientation had been completed on December 5, 2021, which was prior to transfer from another facility. On May 23, 2023, at 10:30 a.m. ULP-D stated she transferred from another facility owned by the same company. When she transferred, she	01470		

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01470	Continued From page 26 followed another staff member for half a day and then was on her own. She did not have training at this facility; however, a registered nurse (RN) had trained her at the other facility. On May 23, 2023, at 1:00 p.m. LALD/LPN-A stated they had ULP that were shared with another facility owned by the same company. The ULP were not trained at each facility since it was the same company. She was unaware that training needed to be completed for each licensee. ULP-C transferred from another facility on March 9, 2023 and ULP-D transferred from another facility on January 3, 2022. She had completed the training with ULP-C. The Educare modules reflect what had been completed so if it was missing, then it was not done. She was unaware the staff were required to complete training at both facilities. On May 25, 2023, at 1:20 p.m. clinical nurse supervisor (CNS)-B stated since the staff transferred from a different facility or were rehired, she was unaware training for each licensee was required. The licensee's Competency Training Evaluations dated August 1, 2021, identified "Training and competency evaluations for all ULP will include: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

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01470	Continued From page 27 (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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01730 SS=D	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	01730		

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01730	Continued From page 28 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; (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 ensure individual medication management plan included medication set up services 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, but was not likely to	01730		

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01730	Continued From page 29 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: R2 was admitted February 8, 2023. R2's Service Plan dated February 8, 2023, and current service plan dated May 8, 2023, identified R2 received services including medication assistance, bathing, morning cares, housekeeping and laundry. R2's service plan failed to identity R2 received medicaion set up services. R2's significant change assessment dated May 8, 2023, failed to identify R2 required medication set up services. On May 23, 2023, at 9:45 a.m., the surveyor observed R2 laying in his bed. There was an unidentified person assisting R2 with cares. Unlicensed personnel (ULP)-C entered the room and gave R2 some medications from a medication cup. On May 23, 2023, at 1:02 p.m. ULP-D was observed checking R2's blood glucose. R2's Med (medication) Setup/Review Summary for the month of May 2023, identified R2's medications had been set up for the month of May 1, 2023, on April 28, 2023, by licensed assisted living director/licensed practical nurse (LALD/LPN)-A. On May 25, 2023, clinical nurse supervisor	01730		

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01730	Continued From page 30 (CNS)-B stated medication set up should have been identified on the medication assessment and plan. The licensee's Medication Management: Assessment, Monitoring & Reassessment policy dated August 1, 2021, identified "Site will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided." The licensee's Service Plan policy dated August 1, 2021, identified "A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of personnel who will be providing services (RN, LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration	01750		

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01750	Continued From page 31 When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-D) completed training and competency evaluations for medication administration. In addition, ULP-C failed to complete an air shot according to manufacturer directions prior to administering insulin from an insulin pen for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on January 3, 2022, to provide direct care and services to residents under the assisted living licensure. ULP-D worked at	01750		

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01750	Continued From page 32 another facility owned by the same company prior to working for this licensee. On May 23, 2023, at 10:02 a.m. the surveyor observed ULP-D administer oral medications, eye drops, topical medications, and nasal spray to R4. ULP-D's Minnesota Comprehensive Home Care Orientation and Requirements was dated February 20, 2021, 11 months prior to ULP-D being hired by the licensee. Registered nurse (RN) skills competencies for medication administration was included. ULP-D's Educare training transcript printed May 23, 2023, identified ULP-D had completed medication administration training February 9, 2021. On May 23, 2023, at 10:30 a.m. ULP-D stated she transferred from another facility owned by the same company. When she transferred, she followed another staff member for half a day and then was on her own. She did not have training and competencies completed at this facility; however, a RN had trained her at the other facility. On May 23, 2023, at 1:00 p.m. licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated they had ULP that were shared with another facility owned by the same company. The ULP were not trained and competencied at each facility since it was the same company. She was unaware that training and competencies needed to be completed for each licensee. ULP-D transferred from another facility on January 3, 2022. She had completed her medication training and competencies at the	01750		

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01750	Continued From page 33 prior facility. She was unaware the staff were required to complete training at both facilities. On May 25, 2023, at 1:20 p.m. clinical nurse supervisor (CNS)-B stated since the staff transferred from a different facility, she was unaware training for each licensee was required. Improper insulin administration ULP-C was rehired on May 9, 2023, to provide direct care and services to residents under the assisted living licensure. On May 23, 2023, at 8:45 a.m. ULP-C was observed administering Levemir insulin and Victoza (diabetic injectable medications) to R3. ULP-C removed the Levemir insulin pen from the medication cart, turned the dial to 5, pushed the button in, placed the needle on the pen, and then dialed the pen to the prescribed dose. ULP-C stated this was the process for R3: they were to clear for 5 prior to putting on the needle and this was how she was trained to do it per the online learning module. ULP-C then removed the Victoza pen from the medication cart and stated "Victoza has a prime line and again we do that before placing the needle." She then dialed the pen to the prime line, depressed the button, placed the needle and dialed the Victoza pen to the appropriate dose. On May 25, 2023, at 2:45 p.m. clinical nurse supervisor (CNS)-B stated staff were trained to put the needle on the insulin pen, waste two units and then dial the pen to the appropriate dose. It would be important to put the needle on first so that it get rid of and air and primes the needle.	01750		

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01750	Continued From page 34 The Licensee's Competency Training Evaluations dated August 1, 2021, identified "A RN (or other licensed health professional where appropriate) will determine what nursing services may be delegated to properly trained and competency tested ULP. 2. Only ULP who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. 3. The site will have a system in place to communicate up-to-date information to a RN regarding current available personnel and their competencies. 4. Training and competency evaluations of ULP's will be conducted by a RN, or another instructor may provide the training in conjunction with a RN. 5. Training and competency evaluations for all ULP's will include:" - "Administering medications or treatments as required." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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:	01880		

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01880	Continued From page 35 Based on observation, interview, and record review, the licensee failed to ensure one of one medication refrigerator was securely locked permitting only authorized personnel to have access. This had the potential to affect all residents residing in the facility. In addition, the licensee failed to ensure refrigerated medications were stored at the appropriate temperature in 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) 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 May 23, 2023, at 9:35 a.m. the surveyor observed a medication refrigerator in a staff room. The door to the staff room was propped open and accessible to staff, residents, and visitors. The medication refrigerator had a padlock hanging on a latch that was open and unlocked. The latch was hanging crooked and was not able to be latched shut. The surveyor noted there were two thermometers in the refrigerator and both thermometers identified the temperature to be 50 degrees Fahrenheit. Upon review of a document on the refrigerator titled Medication Refrigerator Temperature Log, identified the temperature of the refrigerator should be maintained between 36 and 46 degrees Fahrenheit. If the temperature was outside that range, staff were to adjust the dial as needed and recheck the temperature in one hour.	01880		

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01880	Continued From page 36 "Notify ONCALL [sp] if outside these temperature ranges." The log identified rows for the day of the month and columns for NOC (night), AM, and PM staff recording for the month of May 2023. It identified the following data either above the listed temperature range or missing data: - May 1 - PM 49 - May 3 - PM 49 - May 5 - NOC 48, PM 47 - May 6 - NOC blank, PM 46 - May 7 - NOC 48, PM 49 - May 8 - NOC 48, PM blank - May 9 - NOC 49, PM 48 - May 10 - NOC 50, AM 48, PM 48 - May 11 - NOC 50, AM blank, PM 49 - May 12 - NOC 49, AM 50, PM 50 - May 13 NOC 49, AM 48, PM 48 - May 14 NOC 49, AM 48, PM 49 - May 15 AM blank, PM 48 - May 16 NOC 48, - May 17 NOC 49, PM 48 - May 18 NOC 50, AM 48, PM 49 - May 19 NOC 50, AM 49, PM 49.2 - May 20 NOC 50, AM blank, PM 50 - May 21 NOC 50, AM blank, PM 51 - May 22 NOC 51, AM 49, PM 51.5 - May 23 NOC blank, AM 51 21 of the 23 days recorded for May 2023, had temperatures higher than 46 degrees Fahrenheit. On May 23, 2023, at 9:35 a.m. unlicensed personnel (ULP)-D stated the latch had been broken and she had notified maintenance. ULP-D stated the refrigerator temperature should be kept between 36 and 46 degrees Fahrenheit as noted on the Medication Refrigerator Temperature Log that was hanging on the refrigerator. On May 23, 2023, at 10:11 a.m. licensed assisted	01880		

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01880	Continued From page 37 living director/licensed practical nurse (LALD/LPN)-A stated the refrigerator should have been locked. The broken latch should have been reported to maintenance in a communication book for maintenance. The broken latch was not noted in the communication book. The temperature should be between 36 and 46 degrees Fahrenheit as instructed on the Medication Refrigerator Temperature Log. Staff should have notified maintenance that the temperature was not within the required range. The medications stored in the refrigerator observed with LALD/LPN-A included the following: R2 - Lantus insulin - 31 unopened pens - Novolog insulin - five unopened pens - Ozempic (injectable diabetes medication) - 3 unopened pens R3 - Levemir insulin 46 unit pens - two unopened pens - Levemir insulin 70 unit pens - one unopened pen - Victoza (injectable diabetes medication) - five unopened pens R14 Calcitonin (treats osteoporosis) nasal spray - one unopened bottle Lantus prescribing information dated November 2018, identified unopened Lantus pens were to be stored at temperatures between 36 and 46 degrees Fahrenheit. Novolog prescribing information dated December	01880		

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01880	Continued From page 38 2012, identified unopened Novolog was to be stored in the refrigerator with temperatures between 36 and 46 degrees Fahrenheit. Ozempic prescribing information dated December 2017, identified unopened Ozempic pens were to be stored in the refrigerator with temperatures between 36 and 46 degrees Fahrenheit. Levemir prescribing information dated January 2019, identified unopened Levemir pens were to be stored in the refrigerator with temperatures between 36 and 46 degrees Fahrenheit. Victoza prescribing information dated August 2017, identified unopened Victoza pens were to be stored in the refrigerator with temperatures between 36 and 46 degrees Fahrenheit. Calcitonin prescribing information dated September 2017, identified unopened bottles of Calcitonin were to be stored in the refrigerator with temperatures between 36 and 46 degrees Fahrenheit. No further information was provided. TIME PERIOD FOR CORRECTION: seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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	23658	A. BUILDING: _____ B. WING _____	05/31/2023

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01890	Continued From page 39 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened, and had a pharmacy label in two of two medication carts (A and B) 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: On May 23, 2023, at 8:40 a.m. unlicensed personnel (ULP)-C administered medications to R3. R3 received oral medications and subcutaneous injections of Levemir insulin and Victoza (diabetic medication). At 9:07 a.m. ULP-C administered eye drops to R6. On May 23, 2023, at 8:50 a.m. a review of medication cart A was completed with ULP-C with the following findings: R6 - R6 had multiple eye drops in a plastic bin in the top drawer. None of the bottles were in the prescription labeled bottle or boxes. The prescription labeled bottles and boxes with pharmacy labels were stored separately in the cart. The following eye drops were in the bin: - brinzolamide eye drops had a pharmacy label that was torn off and unable to read the prescribing information. ULP-C stated the	01890		

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01890	Continued From page 40 medication came in a prescription bottle with a pharmacy label that she opened the other day, but the prescription bottle was missing. There was an empty box with a pharmacy label and she placed the bottle into the box; - Refresh tears eye drops had a small pharmacy label that contained R6's name, the name of the medication, and directions for use but was missing a prescription number and the prescriber; - Refresh gel eye drops had a small pharmacy label on the bottle that was torn off and no legible information was present on the remaining piece of the label; - Refresh PM ointment had a small pharmacy label that contained R6's name, the name of the medication, and directions for use but was missing a prescription number and the prescriber; - travoprost eye drops which had a small pharmacy label that contained R6's name, the name of the medication, and directions for use but was missing a prescription number and the prescriber; - rhopressa eye drops had a small pharmacy label that was illegible, there was no open or expiration date on the bottle. ULP-C stated it could be confusing since she had so many eye drops and three different Refresh eye drops/ointments. The bottles should have been stored in the original pharmacy labeled bottle or box. - R8 -Ipratropium nasal spray which had a small pharmacy label that contained R8's name, the name of the medication, and directions for use but was missing a prescription number and the prescriber.	01890		

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01890	Continued From page 41 The remainder of the of the medication cart audit was completed with licensed assisted living director/licensed practical nurse (LALD/LPN)-A: - R2 - Lantus insulin pen had no pharmacy label and failed to have an open date. - Novolog insulin pen failed to have an open date. - R9 - a bottle of Thera Tears eye drops stored separately from the prescription labeled bottle. It had a small label on the eye drop bottle that was illegible. - R10 - a bottle of Akwa Tears eye drops stored separately from the prescription labeled bottle. It had a small label on the eye drop bottle which did not have a legible prescription number. Medication cart B On May 23, 2023, at approximately 9:10 a.m. a review of medication cart B was completed with LALD/LPN-A with the following findings was observed: - R11 - two bottles of Nystop powder (antifungal) in a plastic bin. Neither bottle had a pharmacy label or were marked in any way with R11's name; - two bottles of Debrox (softens ear wax) ear drops. Neither bottle had a pharmacy label or were marked in any way with R11's name. - R12 - Arthricream rub (pain reliever) had a small pharmacy label that contained R12's name, the	01890		

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01890	Continued From page 42 name of the medication, and directions for use but was missing a prescription number and the prescriber; - Lubricating eye drops had a small pharmacy label that contained R12's name, the name of the medication, and directions for use but was missing a prescription number and the prescriber. - R13 - Refresh eye drops had a small pharmacy label that contained R13's name, the name of the medication, and directions for use but was missing a prescription number and the prescriber. - Lubricant eye drops which did not have a pharmacy label and was not marked in any way with R13's name. - R7 - Systane (rewetting) eye drops which did not have a pharmacy label and the bottle was marked with R7's initials. - R4 - two bottles of Nystop powder in a plastic bin. Neither bottle had a pharmacy label or were marked in any way with R4's name; - Fluticasone (for allergies) nasal spray had a small pharmacy label that contained R4's name, the name of the medication, and directions for use but was missing a prescription number and the prescriber. - Prednisolone eye drops (steroid) had a small pharmacy label that contained R4's name, the name of the medication, and directions for use but was missing a prescription number and the prescriber. - sodium Chloride (reduces swelling) eye drops had a small pharmacy label that contained R4's name, the name of the medication, and directions for use but was missing a prescription	01890		

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01890	Continued From page 43 number and the prescriber. On May 23, 2023, at 9:10 a.m. LALD/LPN-A stated medications should have a full pharmacy label to include all the information and medications should be stored with the original pharmacy labeled container. Time sensitive medications should be dated when opened. Rhopressa prescribing information dated December 2017, identified "After opening, the product may be kept at 2°C to 25°C (36°F to 77°F) for up to 6 weeks." NovoLog (aspart) FlexTouch pen prescribing information dated February 2015, identified "The NovoLog FlexTouch Pen you are using should be thrown away after 28 days, even if it still has insulin left in it." Lantus SoloStar prescribing information dated November 2018, identified "Once you take your SoloStar out of cool storage, for use or as a spare, you can use it for up to 28 days." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01950		

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01950	Continued From page 44 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: (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 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-D) completed training and competency evaluations for blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on January 3, 2022, to provide direct care and services to residents under the assisted living licensure. ULP-D worked at another facility owned by the same company prior to working for this licensee.	01950		

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01950	Continued From page 45 On May 23, 2023, at 1:02 p.m. ULP-D was observed checking blood glucose on R2. ULP-D's Minnesota Comprehensive Home Care Orientation and Requirements was dated February 20, 2021, 11 months prior to ULP-D being hired by the licensee. Registered nurse (RN) skills competencies for blood glucose monitoring was included. ULP-D's Educare training transcript printed May 23, 2023, identified ULP-D had completed blood glucose testing training on February 9, 2021. On May 23, 2023, at 10:30 a.m. ULP-D stated she transferred from another facility owned by the same company. When she transferred, she followed another staff member for half a day and then was on her own. She did not have training and competencies completed at this facility; however, a RN had trained her at the other facility. On May 23, 2023, at 1:20 p.m. licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated they had ULP that were shared with another facility owned by the same company. The ULP were not trained and deemed competent at each facility since it was the same company. She was unaware that training and competency needed to be completed for each licensee. ULP-D transferred from another facility on January 3, 2022. She had completed her blood glucose testing training and competency at the prior facility. She was unaware the staff were required to complete training at both facilities. On May 25, 2023, at 1:20 p.m. clinical nurse supervisor (CNS)-B stated since the staff	01950		

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01950	Continued From page 46 transferred from a different facility, she was unaware training for each licensee was required. The Licensee's Competency Training Evaluations dated August 1, 2021, identified "A RN (or other licensed health professional where appropriate) will determine what nursing services may be delegated to properly trained and competency tested ULP. 2. Only ULP who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. 3. The site will have a system in place to communicate up-to-date information to a RN regarding current available personnel and their competencies. 4. Training and competency evaluations of ULP's will be conducted by a RN, or another instructor may provide the training in conjunction with a RN." "Nursing tasks that are frequently delegated to unlicensed personnel that would require training and competency testing by a RN include (this list is not all inclusive): Use of glucometers." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=I	144G.91 Subd. 4 (a) 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	02310		

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02310	Continued From page 47 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 provide care and services according to acceptable health care, medical, or nursing standards for two of two residents (R2, R4) with side rails. This resulted in an immediate order issued on May 24, 2023, at 12:35 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 began receiving services under the Assisted Living Facility license on February 8, 2023. On May 23, 2023, at 9:45 a.m., surveyor observed R2 in his bed laying on his left side with a U-shaped consumer grab bar on the left side of the bed. The grab bar went all the way to the floor and there were two bars that went under the mattress. The grab bar was slid out from between the mattress and box spring at an angle, creating a gap of approximately one inch on the bar proximal to the head of the bed and approximately six inches on the bar distal to the head of the bed. There was an unidentified	02310		

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02310	Continued From page 48 person assisting R2 with cares and ULP-C in the room with R2. On May 23, 2023, at 10:21 a.m., surveyor and licensed assisted living director/licensed practical nurse (LALD/LPN)-A, observed R2 alone in his room with the grab bar in the previously noted position. LALD/LPN-A stated that the grab bar should not be pulled out like and should be tight against the bed to prevent an entrapment risk. LALD/LPN-A pushed the grab bar in so that it was snug against the mattress. R2's preadmission assessment dated February 7, 2023, identified R2 had a grab bar on his bed. R2's admission assessment dated February 10, 2023, identified bed safety - standard bed. The assessment lacked documentation R2 had a grab bar on his bed. R2's Clinical Update Assessment 14-da, dated February 28, 2023, identified under bed safety section, R2 had an "OTC [over the counter] grab bar." The assessment failed to identify the rail had been installed according to manufacturer's instructions and failed to identify if the Consumer Product Safety Commission (CSPC) website had been checked for recalls. R2's Clinical Update Assessment - Significant Change - 90 day dated May 23, 2023, identified under bed safety section, R2 had an "OTC [over the counter] grab bar." The assessment failed to identify the rail had been installed according to manufacturer's instructions and failed to identify if the CSPC website had been checked for recalls. R2's Risk/Benefit Agreement - Bed Rail dated May 9, 2023, identified it was the initial	02310		

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02310	Continued From page 49 agreement and R2 used the rail for turning and repositioning. There were risks associated with bed rail use and they had been discussed with the resident and responsible party. R2 had a consumer type grab rail. Brand/manufacturer was listed as "Latex Int." and model/serial number was listed as "8750". The agreement failed to identify the rail had been installed according to manufacturer's instructions and failed to identify if the CSPC site had been checked for recalls. The surveyor was unable to locate manufacturer's instructions online using the documented brand and model. Manufacturer's instructions for the grab bar were requested and were not provided. R4 R4 began receiving services under the Assisted Living Facility license on August 1, 2021. On May 24, 2023, at 10:30 a.m., surveyor observed a consumer type half bed rail on the right side of R4's bed. It had three parallel bars with the top bar having an M shape, and two vertical bars on each end. The legs of the vertical bars went to the ground and there were bars that slid between the mattress and box spring. R4 stated she used the bed rail to assist to reposition, get up from bed, and transfer. R4's Clinical Update Assessment - 90 Day dated April 4, 2023, identified R4 did not have a bed rail. R4 Risk/Benefit Agreement - Bed Rail dated September 6, 2022, indicated R4 used the bed rail to promote independence with bed mobility. There were risks associated with bed rail use and they had been discussed with the resident and responsible party. R4 had a consumer type grab	02310		

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02310	Continued From page 50 rail. Brand/manufacturer was listed as "Medline" and model/serial number was listed as "MD56800BAM Lot 393211 20001." The document failed to identify the rail had been installed according to manufacturer's instructions and failed to identify if the CSPC site had been checked for recalls. On May 24, 2023, at 11:57 a.m., clinical nurse supervisor (CNS)-B stated R2's family installed his grab bar. CNS-B stated the licensee had the manufacturer name but did not check the installation to assure it was properly installed. CNS-B stated that was the responsibility of the family. CNS-B stated that she checked for recalls but it was not documented anywhere. CNS-B stated she assessed for proper use of consumer rails but did not spend a lot of time on them. CNS-B said none of the staff at the facility assured proper installation of any consumer type grab bars or side rails and it was the responsibility of the families. CNS-B stated she was unaware of The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) as it related to side rails. The licensee's 11.29 Side Rails policy dated August 1, 2021, identified "When site is aware a home care resident is utilizing side rails (a medical device) on a bed, site will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail." The MDH website, Assisted Living Resources &	02310		

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02310	Continued From page 51 FAQs indicated, "Licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information ... To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint... Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreement.s" No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

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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
02310	Continued From page 52 On May 25, 2023, at 2:44 p.m. the immediacy was removed based on observations by the surveyor and record reviews by the evaluation supervisor; however, non-compliance remains at a scope and level of I.	02310		

Minnesota Department of Health
Division of Environmental Health
Food, Pools, and Lodging
12 Civic Center Plaza, Se 2105
Mankato, MN

Type: Full
Date: *05/31/23*
Time: 11:20:37
Report: 1028231089

Food and Beverage Establishment Inspection Report

Location:
President
1005 Milwaukee Street
Lakefield, MN56150
Jackson County, 32

Establishment Info:
ID #: 0039273
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3203020192
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 190 Degrees Fahrenheit
Location: Dish Machine - Rinse
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator - Ambient
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -10 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 10 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

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

This Inspection was conducted in conjunction with HRD.

Food is catered in from the adjoining Colonial Manor Nursing Home and served in a serving kitchen.

Type: Full
Date: *05/31/23*
Time: 11:20:37
Report: 1028231089
President

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1028231089 of 05/31/23.

Certified Food Protection Manager: Apryl R. Pohlman

Certification Number: FM82099 Expires: 08/22/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Kayla Spangler
Admin Assistant

Signed: _____

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