DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE AND SURVEY RESULTS

Electronic Delivery

August 8, 2022

Administrator
Millstream Commons
210 West 8th Street
Northfield, MN 55057

RE: Initial License Number 404101
Health Facility Identification Number (HFID) 30490
Project Number SL30490015

Dear Administrator:

On June 28, 2022, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the initial evaluation completed February 18, 2022. The follow-up evaluation determined your facility corrected some but not all of the state licensing orders. **Based on the improvements, the conditions of the license were removed effective June 25, 2022, however non-compliance remains.**

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on February 18, 2022, found not corrected at the time of the June 28, 2022, follow-up evaluation and subject to a penalty assessment are as follows:

0730-Contents Of Resident Record-144g.43 Subd. 3
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)
1730-Individualized Medication Management Plan-144g.71 Subd. 5
2310-Appropriate Care And Services-144g.91 Subd. 4

The details of the violations noted at the time of this follow-up evaluation completed on June 28, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon complaint evaluations, and as otherwise needed. 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).

IMPOSITION OF FINES:

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.

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. 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

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 Jodi Johnson, Supervisor, at jodi.johnson@state.mn.us, or 507-344-2730.

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30490	A. BUILDING: _____ B. WING _____	R 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLSTREAM COMMONS	**210 WEST 8TH STREET NORTHFIELD, MN 55057**

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL30490015 On June 27, 2022, through June 28, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 18, 2022. At the time of the survey, there were thirty-three (33) residents: eighteen (18) receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{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.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health	{0 730}		

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{0 730}	Continued From page 2 records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of content in the resident's record as required for two of two residents (R1, R9) with records reviewed.	{0 730}		

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{0 730}	Continued From page 3 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 R1's record lacked documented information for medical service providers. R1's Face Sheet printed June 28, 2022, included pharmacy name and hospital name, but lacked the address and phone number for the listed pharmacy and hospital. R9 R9's record lacked documented information for medical service providers. R9's Face Sheet printed June 27, 2022, included pharmacy name and phone number, but lacked the address for the listed pharmacy and included hospital name, but lacked the address and phone number for the listed hospital. On June 28, 2022, at 3:06 p.m., registered nurse consultant (RNC)-M stated it was "a system issue. I'll have to call Eldermark [computer system]", regarding why the information above was not able to be inputted into R1 and R9's electronic health record. The licensee's Resident Record Information and Content policy dated April 28, 2022, indicated the	{0 730}		

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{0 730}	Continued From page 4 licensee would have appropriate and accurate records for each resident that was receiving assisted living services. The policy further indicated the resident record would include the names, addresses and telephone numbers of the resident's health and medical service providers, if known. No further information was provided.	{0 730}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	{0 810}		

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{0 810}	Continued From page 5 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The	{01640}		

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{01640}	Continued From page 6 facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to revise the service plan with changes in service for one of one resident (R1) with record 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 service plan lacked revision to include the service of medication set up by the nurse. R1's diagnoses included dementia and diabetes. R1's Medication Sheet dated June 2022, (documentation of unlicensed personnel	{01640}		

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{01640}	Continued From page 7 administration of medications) indicated "found in mediplanner" (a medication cassette) for some of the listed medications. In addition, R1's record included Medication Sheets dated June 2022, showing signature by the licensed nurse for set up of medications in mediplanner. R1's Service Plan Agreement dated May 8, 2022, included service of medication administration by unlicensed personnel, but lacked to include the service of medication set up in mediplanner by the registered nurse. On June 28, 2022, at 3:06 p.m., registered nurse consultant (RNC)-M stated, "It's not on there", regarding medication set up in mediplanner by the licensed nurse being on R1's service plan agreement. The licensee's Service Plan Modifications policy dated May 10, 2022, indicated when a resident receiving assisted living services had a change to services the service plan would be amended in writing and signed by the resident or the resident's representative. If the service plan needs to be modified due to a change in the resident's needs the service plan modification form would be completed. The licensee's Service Plan policy dated April 20, 2022, indicated service plans and any revisions or updates would be entered into the resident's record. including notice for change in fees when applicable. No further information was provided.	{01640}		

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{01730}	Continued From page 8	{01730}		
{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 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	{01730}		

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{01730}	Continued From page 9	{01730}		

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 interview and record review, the licensee failed to ensure an individualized medication management plan to include all required content for two of two residents (R1, R9) 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 and R2's record lacked documentation for when the nurse should be notified for administration of medications.

R1
R1's Service Plan Agreement dated May 8, 2022, included the service of medication administration "refer to EMAR [electronic medication administration record]".

R1's Individual Medication Plan dated June 22, 2022, indicated for nurse notification of problems/concerns: "ULP [unlicensed personnel] will contact the licensed nurse 24/7 with any

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{01730}	Continued From page 10 questions or concerns with medication administration". R1's Medication Sheet dated June 2022, included the administration of warfarin (blood thinning medication) daily for anticoagulation and nitroglycerin 0.4 milligrams (mg) every five minutes for chest pain as needed, maximum of three tablets within 15 minutes. R1's record lacked documented evidence when the nurse should be notified for problems related to the administration of the warfarin and nitroglycerin. R9 R9's Service Plan Agreement dated May 23, 2022, included the service of medication administration "administer oral medications, administer medications as ordered, stay with resident until all medications are taken, report difficulties with swallowing to nurse". R9's Individual Medication Plan dated June 17, 2022, indicated for nurse notification of problems/concerns: "ULP will contact the licensed nurse 24/7 with any questions or concerns with medication administration". R9's Medication Sheet dated June 2022, included the administration of nitroglycerin 0.4 mg under tongue once daily as needed. R9's record lacked documented evidence when the nurse should be notified for problems related to the administration of the nitroglycerin. On June 28, 2022, at 3:06 p.m., registered nurse consultant (RNC)-M stated, "We need to add it in there" in regard to when the nurse should be	{01730}		

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{01730}	Continued From page 11 notified related to problems with the administration of the above medications. The licensee's Medication Management Individualized Plan policy dated April 22, 2022, indicated the licensee would develop and maintain current individualized medication management record for each resident that would contain procedures for staff notifying a registered nurse or appropriate health professional when a problem arises with medication management services. No further information was provided.	{01730}		
{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 health care and medical, or nursing standards for one of one resident (R5) who utilized a physical device (u-shaped bars), with record 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	{02310}		

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{02310}	Continued From page 12 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee lacked manufacturer instructions and assessment for installation of u-shaped physical devices on R5's bed according to the manufacturer instructions. R5's record included the following: -Side Rail Assessment Form dated April 25, 2022, indicated continue to assess the bilateral bed rails for safety and security. The bed rails are indicated for resident independence and bed mobility. Resident primary uses one of the bed rails at this time on the side she sleep on. -Risk Agreement Bed Positioning Device dated May 17, 2022, indicated side rails on bed do not fit guidelines. Discussed side rails with resident. Resident stated nursing had went over safety of these side rails. Does have a black covering over the side rails. Resident will continue with these side rails regardless of safety issues. The agreement indicated the resident had been educated about the high risk of entrapment. On June 27, 2022, at 12:03 p.m., observation with registered nurse consultant (RNC)-M of R5's bed identified u-shaped bars (with black mesh covers over both) physical devices on the upper right and upper left sides of R5's bed. The u-shaped physical devices were securely attached to R5's bed. RNC-M stated the licensee did not have the manufacturer instructions for the u-shaped bars on R5's bed. RNC-M stated regarding who attached the u-shaped physical devices to R5's bed, "I don't know who attached." RNC-M stated she would obtain the manufacturer instructions and find out who attached the	{02310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30490	A. BUILDING: _____ B. WING _____	R 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLSTREAM COMMONS	**210 WEST 8TH STREET NORTHFIELD, MN 55057**

(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 13 u-shaped bars to R5's bed. At 1:17 p.m., RNC-M provided the manufacturer guidelines and stated a family member of R5's had attached the u-shaped bars to R5's bed. RNC-M stated' "I checked, installed properly", regarding the u-shaped bars being installed according to the manufacturer instructions. The manufacturer instructions provided by RNC-M indicated the "product name" for the u-shaped bars was "bed rail"and "keep the product at least 12.5 inches from the head and foot end plane of the bed to help prevent entrapment issues. It is important that the bed rail is secured to the side of the mattress. The safety strap is looped around the bed frame on the opposite side of the bed, buckled, and tightened. The maximum user weight was 300 lbs. [pounds]. Mattress thickness range 8 in [inches]." The licensee's Side Rails policy dated May 2, 2022, indicated when the licensee was aware a home care resident was utilizing side rails (a medical device) on a bed, the licensee would 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 was of a safe design and utilized consistent with manufacturer's directions. The policy would be followed regardless of who owns or is supplying the side rail. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	{02310}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

In the Matter of Millstream Commons
Millstream Commons
210 West 8th Street
Northfield, MN 55057

MDH HFID #30490
License Number 404101
Project Number SL30490015

Stipulation and Consent Order:

IT IS STIPULATED AND AGREED by Millstream Commons and the Minnesota Department of Health ("Department" or "MDH"), that without trial or adjudication of any issue of fact or law both parties agree to enter into this agreement.

This Stipulation and Consent Order ("Stipulation"), evaluation reports, and related documents shall constitute the entire record upon which this Stipulation is based. The evaluation results and public documents dated February 18, 2022, through the date of this Stipulation, as listed below in the Facts and Law, are incorporated by reference into this Stipulation. This Stipulation is public data pursuant to Minn. Stat. § 144.051, Subd. 4 and the provisions of the Minnesota Government Data Practices Act, Minn. Stat. Ch. 13

Facts and Law:

1. Minn. Stat. § 144G.01 - Minn. Stat. § 144G.95, authorize MDH to regulate licensed assisted living facilities in Minnesota. This authority includes issuing licenses and conducting evaluations to determine if a license holder is in compliance with statutory requirements of licensed assisted living facilities.

2. Millstream Commons has been licensed to provide assisted living services since August 1, 2021.

3. On February 18, 2022, the Department conducted an evaluation for the purpose of assessing compliance with State licensing regulations Project Number SL30490015. This evaluation resulted in 41 orders, including 35 Level 2 violations and one Level 3 violation.

Current Status

Millstream Commons Executive Director, Lindsey Swartwood, met informally with MDH during conference calls on March 31, 2022. During the call, MDH shared their concerns about the evaluation completed on February 18, 2022 and provided Millstream Commons with the option of a stipulated agreement. During the informational conference, Millstream Commons shared

what actions they are taking to bring Millstream Commons into compliance. Additional communications followed, and Millstream Commons decided to proceed with a stipulated agreement.

Under this agreement, Millstream Commons will take immediate steps to correct all violations under a conditional license. MDH plans to issue the conditional license using a stipulated agreement

Conditional License Issued:

MDH will issue Millstream Commons a conditional assisted living facility license for 90 calendar days from the effective date of this Stipulation. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30 Subd. 6. Based on the results of the evaluation, MDH will determine if Millstream Commons is in compliance.

The following conditions apply on the conditional comprehensive license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Millstream Commons will not admit any new residents under its conditional assisted living license until the MDH removes the "no new admissions" condition. On the date the agreement is signed by Millstream Commons, they must provide the Department:

    i. A list of the names and birthdates of any individuals Millstream Commons is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents by location including:
        1. Name and birthdate of each resident
        2. Physical location of each resident
        3. Current payment source for services
        4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** Millstream Commons will contract with an RN to provide consultation concerning all residents to whom Millstream Commons provides licensed assisted living services under the conditional license. The consultant must have access to all residents receiving services from Millstream

Commons. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Millstream Commons and MDH must review the RN's credentials and approve the selection. Millstream Commons is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Millstream Commons in an effort to help Millstream Commons align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.95 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. Millstream Commons will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Millstream Commons and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jodi.johnson@state.mn.us. Jodi Johnson can be reached at 507-344-2730 (office) with questions about reports. The content of the reports will include information such as:

   i. Progress towards correction of licensing orders;
   ii. Observations of staff delivering assisted living services and the level of competency observed;
   iii. Conversations with residents and family members about satisfaction with assisted living services;
   iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
   v. Overall impressions about the quality of the assisted living services delivered;
   vi. Overall impressions about the dignity with which the residents and their family members are treated;
   vii. Concerns; and
   viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Millstream Commons to correct the violations cited during the evaluation as well as to determine the overall practice of Millstream Commons in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. **Follow-up Evaluation:** At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** Millstream Commons will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
   i. A statement of the concern
   ii. A description of what will happen to correct the concern
   iii. A target date for when each correction will be complete
   iv. Who is responsible to make sure it happens
   v. Current status of correction work
   vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

Results of Follow-Up Survey During the Conditional License Period:

MDH will determine if Millstream Commons is in compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Millstream Commons is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Millstream Commons' assisted living facility license, and Millstream Commons will correct violations detected during the evaluation to come into full compliance. If MDH determines Millstream Commons is not in substantial compliance, MDH may take additional enforcement action against Millstream Commons, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

Binding Effect:

This Agreement is binding upon the Parties, their employees, agents, heirs, administrators, representatives, executors, successors and assigns, and the Parties will assure that their employees, agents, heirs, administrators, representatives, executors, successors, and assignees are made aware of this agreement.

No Limited Authority:

This Stipulation does not in any way or manner limit or affect the authority of MDH to take additional enforcement action against Millstream Commons based on any act, conduct, or admission of Millstream Commons which justifies enforcement action and occurred either before or after the date of this Stipulation and which is not directly related to the facts and circumstances covered in this Stipulation.

Procedure:

This Stipulation contains the entire agreement between MDH and Millstream Commons, there being no other agreement of any kind, verbal or otherwise, which varies this Stipulation. Provider understands that this agreement is subject to the Division Director's approval.

Service of Agreement:

MDH will scan and provide a copy of the signed Stipulation to Millstream Commons. By this Stipulation, Millstream Commons agrees that the signed and scanned copy of the Stipulation is considered to be personal service upon Millstream Commons and at which time this Stipulations becomes effective. Upon any application of the Division Director, any appropriate federal or state court will enter an order of enforcement of any or all of the terms of this Stipulation.

Execution:

Millstream Commons has carefully read the Stipulation, understands the contents of it and signs it under its own free will:

Millstream Commons

Lindsey Swartwood, Executive Director

Dated: April 14th, 2022

Upon consideration of this Stipulation, by the Division Director, it is ordered that the terms in this Stipulation are adopted on this_____15th_____day of_ April___, 2022. This executed Stipulation will be effective on the date it is electronically received by Millstream Commons.

Maria King, RN
INTERIM DIVISION DIRECTOR

Minnesota Department of Health
Health Regulation Division

Maria King, RN, Interim Division Director

Electronically Delivered
March 28, 2022

Administrator
Millstream Commons
210 West 8th Street
Northfield, MN 55057

RE: Project Number(s) SL30490015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on February 18, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for

the same circumstance.

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

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

St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $3,000.00

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

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

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

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

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

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

Free from Maltreatment reconsideration requests should 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**.

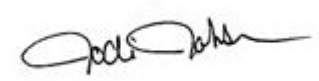
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

INFORMAL CONFERENCE
At any time, the Commissioner of Health is authorized by Minn. Stat. § 144G.20, subd. 20 to hold an informal conference to exchange information, clarify issues, or resolve issues.

The Minnesota Department of Health staff would like to schedule a conference call with Millstream Commons. Please contact Jodi Johnson at 507-344-2730, on or before Thursday March 31, 2022, to schedule the conference call.

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: 507-344-2730 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30490	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

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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#30490015 On February 15, 2022, through February 18, 2022, 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 34 residents, of which 20 residents were receiving services under the provider's Assisted Living license. On February 17, 2022, the immediacy of correction order 2310 has been removed; however, non-compliance remains at a scope and level of D.	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.	
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1	0 250		

provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:
(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;
(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;
(3) performs any act detrimental to the health, safety, and welfare of a resident;
(4) obtains the license by fraud or misrepresentation;
(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;
(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;
(7) interferes with or impedes a representative of the department in contacting the facility's residents;
(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4;
(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;
(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;
(11) refuses to initiate a background study under section 144.057 or 245A.04;
(12) fails to timely pay any fines assessed by the

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required, 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 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 entrance conference on February 15, 2022, at approximately 9:50 a.m. licensed assisted living director (LALD)-A and executive director (ED)-B stated they "try to be" familiar with the Assisted Living licensing laws and rules.	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 250	Continued From page 3 The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying	0 250		

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0 250	Continued From page 4 a license. I understand that information submitted to the commissioner in the application may, in some circumstances, be disclosed to the appropriate state, federal or local agency, and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659	0 250		

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0 250	Continued From page 5 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. Page five was electronically signed by LALD-A on May 13, 2021. The licensee had an Assisted Living license, issued on August 1, 2021. The licensee lacked development of the following policies and procedures for: - ensuring that nurses and licensed health professionals have current and valid licenses to practice On February 15, 2022, at 2:45 p.m. LALD-A stated the licensee was in the process of updating policies and procedures for the new Assisted Living regulations. In addition, the licensee failed to implement the following required policies and procedures: - infection control practices; - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - medication and treatment management;	0 250		

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0 250	Continued From page 6 - delegation of tasks by registered nurses or licensed health professionals; - supervision of unlicensed personnel performing delegated tasks; and - implementation of the assisted living bill of rights Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This had the potential to affect all residents, staff and visitors. Refer to licensing order at Statute 144G.42, Subd 6 (b). The licensee failed to ensure an individual abuse prevention plan was developed to include the required content for two of two residents (R1, R2) with records reviewed. Refer to licensing order at Statute 144G.42, Subd 8. The licensee failed to ensure a job description was current and documentation of training and competency for administration of medication for one of two unlicensed personnel (ULP-H) with records reviewed. Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect all residents, staff and visitors. Refer to licensing order at Statute 144G.61., Subd. 2. The licensee failed to ensure training and competency evaluations contained all the required training for one of two unlicensed	0 250		

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0 250	Continued From page 7 personnel (ULP-H) with records reviewed. Refer to licensing order at Statute 144G.61., Subd. 2. (b) The licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-H, ULP-I) with records reviewed. Refer to licensing order at Statute 144G.62., Subd. 5. The licensee failed to ensure documentation of direct supervision of staff performing delegated tasks for one of two unlicensed personnel (ULP-H) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (unlicensed personnel (ULP)-H, ULP-I and registered nurse (RN)-C) with records reviewed. Refer to licensing order at Statute 144G.64, (a) (1) (2). The licensee failed to ensure three of three employees (unlicensed personnel (ULP)-H, ULP-I and registered nurse (RN)-C) received the required amount of dementia care training, with records reviewed. Refer to licensing order at Statute 144G.70, Subd. 2. (b) The licensee failed to ensure a Registered Nurse (RN) conducted an initial assessment and had proposed a temporary service plan for one of two residents (R1) as required, with records reviewed.	0 250		

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0 250	Continued From page 8 Refer to licensing order at Statute 144G.70, Subd. 2. (d) The licensee failed to ensure the registered nurse (RN) had completed and/or documented a comprehensive assessment for change in condition for three of three residents (R4, R2, R1) related to falls. In addition, the licensee failed to ensure the RN conducted ongoing client monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R2, R1) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 1. (c) The licensee failed to ensure the the accountability of controlled substances and failed to ensure medication management policies and procedures were developed under the supervision and direction of a registered nurse (RN), licensed health professional, or pharmacist consistent with current practice standards. In addition, the licensee failed to ensure medication errors were investigated and corrective actions were documented for two of three residents (R2, R5) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 2. The licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided, and how the services would be provided for two of two residents (R1, R2) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 5. The licensee failed to ensure an individualized medication management plan to include all required content for two of two residents (R1, R2) with records reviewed.	0 250		

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0 250	Continued From page 9 Refer to licensing order at Statute 144G.71, Subd. 7. The licensee failed to ensure delegated procedures were followed and the registered nurse (RN) specified, in writing, specific instructions for two of two residents (R1, R2) for administration of medications and one of two unlicensed personnel (ULP-I) was instructed in the proper methods and had demonstrated the ability to competently follow the procedures, with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 8. The licensee failed to ensure prescriptions for medications were transcribed accurately for one of two residents (R1) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 9. The licensee failed to ensure documentation of medication setup as required for one of one resident (R1) who had medications pre-set up, with record reviewed. Refer to licensing order at Statute 144G.71, Subd. 10. (a)(1). The licensee failed to implement policies and procedures for giving accurate and current medications for those residents who received medication management services during planned time away from home. This has the potential to affect all residents. Refer to licensing order at Statute 144G.71, Subd. 10. (a)(2). The licensee failed to ensure the registered nurse (RN) developed written procedures for unplanned time away from home and failed to ensure two of two unlicensed personnel (ULP-H, ULP-I) were trained and had demonstrated competency to prepare and give medications for clients having unplanned time away. This had the potential to affect all the	0 250		

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0 250	Continued From page 10 residents. Refer to licensing order at Statute 144G.71, Subd. 22. The licensee failed to document in the resident's record the disposition of the medication to include the medication's strength for one of one discharged resident (R3) with record reviewed. Refer to licensing order at Statute 144G.72, Subd. 2. The licensee failed to ensure the policy and procedures for treatments and therapy management services included all the required content and written treatment or therapy management policies and procedures were developed under the supervision and direction of a registered nurse (RN), licensed health professional, or pharmacist consistent with current practice standards, with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to develop a treatment management plan to include all required content and failed to ensure a treatment management plan was current for two of two residents (R1, R2) with records reviewed Refer to licensing order at Statute 144G.72, Subd. 4. The licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for two of two residents (R1, R2) and two of two unlicensed personnel (ULP-H, ULP-I) were instructed in the proper methods and had demonstrated the ability to competently follow the procedures, with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 5. The licensee failed to ensure	0 250		

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0 250	Continued From page 11 administration of treatment was discontinued as prescribed for one of two residents (R2) with records reviewed. Refer to licensing order at Statute 144G.91, Subd. 4. The licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R2) with bedrails, with record reviewed. Forty-one (41) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are	0 470		

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0 470	Continued From page 12 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 staffing plan was developed to determine staffing levels to meet the needs of all residents, and the 24-hour staffing schedule was posted with all required information. 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: STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining it's staffing level that: - included an evaluation, to be conducted at least	0 470		

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0 470	Continued From page 13 twice a year, of the appropriateness of staffing levels in the facility; - ensured 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 - ensured 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 STAFFING SCHEDULE The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to include: -direct-care staff member's resident assignments or work location; and -be posted in a central location On February 15, 2022, at approximately 9:30 a.m. a staff schedule was posted on the glass window entrance facing into the facility entrance area. The posting was visible to persons who entered the facility; however, was not visible in a central location in the building for persons to view. In addition, the posted staff schedule lacked direct-care staff member's resident assignments or work location. On February 15, 2022, at approximately 9:50 a.m. executive director (ED)-B stated "We still have to develop that." At 12:57 p.m. licensed assisted living director (LALD)-A verified the posted staff schedule was not posted in a central location visible to persons inside of the facility and lacked the direct-care staff member's resident assignments or work location. The licensee's Staffing, Direct Care Staffing Plan	0 470		

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0 470	Continued From page 14 and Daily Schedule policy dated revised February 15, 2022, indicated the executive director, director of health services, or designee would develop, write, and implement a staffing plan. The director of health services would develop a 24 hour daily staffing schedule. The 24 hour daily staffing schedule would identify care staff member's resident assignments or work location and would be posted in a central location and be 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: (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	0 480		

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0 480	Continued From page 15 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 February 15, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of	0 510		

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0 510	Continued From page 16 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control and 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: BLOOD SUGAR CHECK On February 16, 2022, at 8:17 a.m. unlicensed personnel (ULP)-I was observed to put on gloves and check R1's blood sugar. ULP-I removed gloves and without washing hands applied clean gloves and cleansed R1's glucometer with a Super Sani-Cloth (disinfecting) disposable wipe. Without removing the gloves or washing hands, ULP-I administered insulin to R1 by injection with an insulin pen (an injection device with a needle). At 9:13 a.m., ULP-I verified she had not washed hands or removed gloves as noted above. The licensee's Procedure for Using Gloves policy dated August 1, 2021, indicated complete task and if gloves become torn, heavily soiled and additional tasks must be performed for the	0 510		

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0 510	Continued From page 17 resident, then change gloves (washing hands before putting on new gloves) before starting the next task. The licensee's Hand Hygiene policy dated August 1, 2021, indicated handwashing, which is the single most effective way of controlling the spread of infection, would be preformed by staff routinely and thoroughly to protect residents from the spread of infection. The policy further indicated hands should be washed after removing gloves, if moving from contaminated body site to clean body site during resident care and after contact with environmental surfaces or equipment in the immediate vicinity of the resident. COVID-19 The licensee failed to screen residents for COVID-19 symptoms (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) daily. R1's record lacked evidence of documented daily screening of COVID-19 symptoms. On February 16, 2022, at 8:17 a.m. ULP-I stated the residents temperature and oxygen saturation were documented daily. ULP-I stated, "No" to residents being screened daily for COVID-19 symptoms. On February 16, 2022, at approximately 9:13 a.m. ULP-H stated she checked the residents temperature and oxygen saturation daily for COVID-19 screening. On February 16, 2022, at 1:34 p.m. registered nurse (RN)-C stated, "No" to residents being	0 510		

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0 510	Continued From page 18 screened daily for COVID-19 symptoms. 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 MDH COVID-19 Guidance: Long-term Care Indoor Visitation for Nursing Facilities and Assisted Living-type Settings guidance dated May 20, 2021, indicated facilities should actively screen all residents for fever and respiratory symptoms of illness at least daily and increase monitoring of ill residents to at least three times daily. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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	30490	A. BUILDING: _____ B. WING _____	02/18/2022

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0 550	Continued From page 19 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information related to the grievance procedure, resident advocacy information, and information for reporting suspected maltreatment. 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: The licensee lacked postings in a conspicuous location and a disclosure of resident advocacy to include: -a posting with all required content of the licensee's grievance procedure and the name	0 550		

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0 550	Continued From page 20 and email contact information for the individuals who are responsible for handling grievances; -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and -number and contact information and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On February 15, 2022, at 12:57 p.m. no posted facility grievance procedure was observed in any area of the facility. Administrative assistant (AA)-E stated at the time "I don't believe so" to the facility grievance procedure being posted. At 1:04 p.m. executive director (ED)-B stated, "We don't have that posted yet" regarding the facility grievance procedure being posted. The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated all residents would receive information on the complaint procedure, receive required information on how to contact the Office of Ombudsman for Long-Term Care, Office of the Ombudsman for Mental Health and Developmental Disabilities and the CEP (common entry point). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each	0 630		

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0 630	Continued From page 21 vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the 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 R1's start of care date was October 20, 2021. R1's Service Plan Agreement was dated October 20, 2021, indicated R1 received services which included personal care assitance (dressing in morning and at bedtime, putting on and removal of compression stockings, daily weight), assistance with bathing-shower, housekeeping, blood sugar checks, insulin pen administration	0 630		

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0 630	Continued From page 22 and medication management complex. On February 16, 2022, at 8:17 a.m. unlicensed personnel (ULP)-I was observed to administer oral medications to R1, check R1's blood sugar and administer insulin by injection to R1. R2 R2's start of care date was September 30, 2021. R2's Service Plan Agreement dated September 30, 2021, indicated R2 received services which included personal care assitance (putting on and removal of compression stockings, make bed daily), assistance with bathing-shower, housekeeping, escorts and medication management complex. On February 16, 2022, at 8:58 a.m. ULP-I was observed to administer oral medications to R2. R1 and R2's records lacked an individualized abuse prevention plan, which included an individualized review or assessment of the residents' susceptibility to abuse by another individual, including other vulnerable adults; the residents risk of abusing other vulnerable adults; identified areas of vulnerability and specific measures to minimize the risk of abuse for identified vulnerable areas. On February 15, 2022, at 9:50 a.m. executive director (ED)-B stated, "That is one of the things we need to work on" regarding residents having an individualized abuse prevention plan. The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated each resident receiving nursing services will have an individualized abuse prevention plan. The plan	0 630		

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0 630	Continued From page 23 would include the residents' potential to abuse other another individual/vulnerable adult, resident's risk of abusing other vulnerable adults and interventions to minimize the risk of abuse tot he resident and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=A	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee,	0 650		

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0 650	Continued From page 24 volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure a job description was current and documentation of training and competency for administration of medication for one of two unlicensed personnel (ULP-H) 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 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-H's date of hire was December 16, 2021. ULP-H provided direct care and services to the licensee residents. ULP-H's employee record included a "Job Description" for position of "Nursing Assistant Registered (NAR)"; however, ULP-H was not currently listed on the Minnesota Department of Health (MDH) nursing assistant registry (the nursing assistant registry lists nursing assistants who have met Minnesota training and/or testing standards). In addition, ULP-H's record lacked documentation	0 650		

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0 650	Continued From page 25 of training and competency for administration of insulin medication via an insulin pen. On February 16, 2022, at approximately 9:13 a.m. ULP-H confirmed she provided direct care and services to residents. ULP-H stated, "No" to being a registered nursing assistant. On February 18, 2022, at 10:38 a.m. registered nurse (RN)-C confirmed ULP-H was not a registered nursing assistant and ULP-H's job description for position "Nursing Assistant Registered (NAR)" was inaccurate. RN-C confirmed ULP-H administered insulin medication via an insulin pen to residents. RN-C stated she had trained and had ULP-H demonstrate competency for administering insulin via an insulin pen, but had not documented the training and competency. A policy for job description was requested, but not provided. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated documentation of each unlicensed staff person's training and competency to assist or administer medications would be retained in the personnel record of each staff person who had satisfied the training and competency requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 26 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. 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:	0 660		

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0 660	Continued From page 27 TB RISK ASSESSMENT The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH (Minnesota Department of Health) was dated September 30, 2019, and indicated the TB risk level was "Low." The licensee's TB risk assessment failed to be updated every other year as required. TB PLAN/EDUCATION The licensee lacked a written TB infection control plan for the procedures to address early recognition, isolation and referral for handling residents with suspected or confirmed active TB; therefore, none of the licensee's employees had received training on their role in the procedure. The licensee's policy TB Prevention and Control dated August 1, 2021, indicated "If a case of suspected or confirmed TB disease is identified among staff or residents, we assure that appropriate actions will be taken immediately which may include assistance with arrangement for transfer of the resident to an inpatient facility while collaborating and cooperating with local public health and MDH." The policy also indicated the licensee would establish and maintain a TB prevention and control program based on the most current guidelines issued by the CDC and the MDH guidelines Regulations for TB control in Minnesota Health Care Settings would be followed. The policy further indicated the "agency elects to complete the TB Risk Assessment Annually." The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC	0 660		

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0 660	Continued From page 28 guidelines, indicated all health care settings in Minnesota should perform an initial facility TB risk assessment. Medium-risk settings should update their assessment yearly; low-risk settings should update theirs every other year. Keep your facility's completed TB risk assessment worksheets on file for future reference. A TB infection control program should include the following: written TB infection control procedures. On February 18, 2022, at 9:41 a.m. registered nurse (RN)-C verified the licensee's Facility TB Risk Assessment was not updated every other year as required, and the licensee's policy lacked clear written procedures to address early recognition, isolation and referral for handling clients with suspected or confirmed active TB; therefore, none of the licensee's employees would have received training on their role in the procedure. 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;	0 680		

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0 680	Continued From page 29 (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 to develop an all-hazards emergency preparedness (EP) program and plan to include Appendix Z required elements and failed to ensure a missing resident policy included all required content. This had the potential to affect all 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 failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 30 EMERGENCY PREPAREDNESS PLAN The licensee lacked a posted emergency disaster plan prominently and the licensee "Disaster Plan" dated July 2021 lacked required information according to Emergency Preparedness: Appendix Z. On February 15, 2022, at 12:57 a.m. administrative assistant (AA)-E stated, "We don't have it posted" when the surveyor asked where the emergency disaster plan was posted in the facility. On February 18, 2022, at 8:55 a.m. executive director (ED)-B and AA-E stated the licensee's Disaster Plan was a "work in progress" and no content of the Disaster Plan was "finalized." ED-B and AA-E stated the license had not had any meetings for emergency preparedness plan, but department persons for maintenance and dietary were given portions to work on for emergency preparedness content. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z: - establish/maintain a comprehensive EP which describes the facility's approach to meeting health/safety/security needs staff/residents; - addressing how the licensee would coordinate with other health care facilities. as well as community on a whole during emergency or disaster; - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs), arrangements/contracts to re-establish utility services;	0 680		

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0 680	Continued From page 31 - document risk assessment for an all hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community based risks (evacuation plans, back-up plans) - identification of at risk population needs like maintaining independence, communication, transportation, supervision, medical care, identify which staff would assume specific roles in another's absence through succession planning and delegation of authority and qualified person authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies; - 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 a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing safe evacuation form facility, including care and treatment needs of evacuees;staff responsibilities;transportation;identification of evacuation location(s);primary/a;ternate communication means with external sources of	0 680		

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0 680	Continued From page 32 assistance; - policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure addressing use of volunteers, including the process/role for integration; - policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional and local EP staff; State Licensing and Certification Agency; MN Office of Ombudsman for LTC and other sources of assistance; - communication plan which includes primary and alternate means of communication with facility staff and Federal, State, tribal, regional and local emergency management agencies; - communication plan which includes method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general	0 680		

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	30490	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

(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
0 680	Continued From page 33 condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy, needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and - communication plan which includes method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives - develop and maintain an EP training and testing program; - training program which includes initial training in EP policy and procedure to all new and existing staff, individuals providing services under arrangement, volunteers consistent with their expected role; provide EP training at least annually; maintain documentation of all EP training; demonstrate staff knowledge of EP; - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt form engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise; - if part of a health care system consisting of separately certified healthcare facilities elects to have a unified and integrated EPP, they may choose to participate and if elected demonstrate each separately certified within the system actively participated in the development of the unified and integrated EPP.	0 680		

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0 680	Continued From page 34 MISSING RESIDENT POLICY The licensee's Missing Resident policy dated August 1, 2021, indicated "1. When a resident is believed missing by any staff member, the following steps are promptly implemented: Refer to the Green Elopement binder in each Cottage a. Determine if the resident is away from the building and/or with family, friends, or a staff escort. Check with other staff on duty, communication logs, sign out log, contact family, etc. b. If unable to determine where the resident is, notify other staff in the building and promptly search the facility and premises. 2. If staff are still unable to locate the resident, staff will notify the RN [registered nurse] on call, or designee. 3. Call 911. Have the following information available a. Name of resident b. Date/time resident was last seen c. Name of primary contact/designated representative d. Description including any identifying characteristics and last known clothing. 4. Update resident's designated representative of the situation and steps taken to locate the resident. 5. When the resident is located, update all parties involved including the police, management staff, nurse on call, family, physician, etc. 6. Complete an incident report. Complete notification to the CEP [county entry point/MN adult abuse reporting center (MAARC)] if appropriate. 7. The RN will complete an assessment including approaches to decrease risk of elopement in the future; and will appropriately update any other necessary documentation such as service plans, individual abuse prevention plans, etc.". The licensee's Missing Resident policy lacked the following required content: -(1)identify a staff member for each shift who is responsible for implementing the missing resident	0 680		

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0 680	Continued From page 35 plan, and ensure at least one staff member who is responsible for implementing the missing resident plan is onsite 24 hours a day, seven days a week; -(2)require that the staff alert the staff member identified in sub item (1) immediately if it is suspected that a resident may be missing; -(3)identify staff by position description who are responsible for searching for missing residents or suspected missing residents; -(4)require that staff conduct an immediate and thorough search of the facility, the facility's premises, and the immediate neighborhood in each direction when a resident is suspected of missing; -(5)require that a suspected missing resident be considered missing if the resident is not located after staff complete the search in sub item (4); -(6)require that staff immediately notify local law enforcement when a facility determines, under sub item (5) or otherwise, that a resident is missing; -(7)require that staff immediately contact the resident's representatives and resident's case manager, if applicable, when a resident is determined missing; and -(8)require that staff cooperate with local law enforcement and provided any information that is necessary to identify and locate the missing resident On February 18, 2022, at approximately 8:55 a.m. ED-B verified the licensee's Missing Resident policy lacked the above required content. A policy for the emergency preparedness plan was not provided. No additional information was provided.	0 680		

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0 680	Continued From page 36 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	0 730		

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0 730	Continued From page 37 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of content in the resident's record as required for two of two residents (R1, R2) and documentation of a discharge summary in the resident's record for one of one discharged resident (R3) with record 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 R1's record lacked documented information for contact persons and medical service providers.	0 730		

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0 730	Continued From page 38 R1's Face Sheet printed February 15, 2022, listed "Contacts," but lacked the address of one contact person and the last name and address of another listed contact person. In addition, the face sheet lacked the name, address, and telephone number for listed "Pharmacy" and "Hospital" preference. R2 R2's record lacked documented information for contact persons and medical service providers. R2's Face Sheet printed February 15, 2022, listed "Contacts," but lacked the address of two contact persons listed. In addition, the face sheet lacked the address of the primary physician listed, and the name, address, and telephone number for listed "Pharmacy" and "Hospital" preference. On February 16, 2022, at 1:34 p.m. registered nurse (RN)-C confirmed R1 and R2's records lacked the above content. R3 R3 was discharged on October 5, 2021. R3's Progress Notes dated October 5, 2021, indicated resident was discharged from the facility with his family member, and the family member was given all of R3's medications. R3's record lacked evidence of a discharge summary. On February 15, 2022, at 12:38 p.m. RN-C stated, "I don't see one" in regards to there being a documented discharge summary for R3. The licensee's Resident Records policy dated August 1, 2021, indicated the resident record would contain identifying information about the	0 730		

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0 730	Continued From page 39 resident's family, designated representative or emergency contact identified by the resident including the name and address and names, addresses and telephone numbers of the resident's health and medical service providers and a discharge summary, including service termination notice and related documentation when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 800		

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0 800	Continued From page 40 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour with maintenance (M)-J on February 17, 2022, between approximately 10:45 a.m. and 1:00 p.m., it was observed that the emergency exit lighting that was tested on first and second floor stairwells were not working. These lights are required to be operational to illuminate the path of egress in the event of an emergency if power is lost. This deficient condition was visually verified by M-J accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (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	0 810		

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0 810	Continued From page 41 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; and failed to provide training to residents who are capable of self-evacuation on the actions to be taken in the event of a fire or similar emergency. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 810		

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0 810	Continued From page 42 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on February 17, 2022, between approximately 10:00 a.m. and 10:45 a.m. with the executive director (ED)-B and maintenance (M)-J on the fire safety and evacuation plan and fire safety and evacuation training for the facility. Record review indicated that that the fire safety and evacuation plan did not show fire protection procedures necessary for residents and did not identify any unique or unusual resident needs for movement or evacuation. During interview, ED-B and M-J verified that they did not have either of these provisions in the fire safety and evacuation plan for the facility. Record review indicated that employees did not receive training twice per year after initial hire on the facility fire safety and evacuation plan. During interview, ED-B stated that the licensee provides training to employees at initial hire and annually thereafter. Record review indicated that licensee did not provide training on the proper actions to take in the event of a fire including movement, evacuation, or relocation at least once a year to residents who are capable of assisting in their own evacuation. During interview, ED-B and M-J verified that they have not provided this training and did not have a policy in place indicated that they would be conducting this training annually as required by statute. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 43 (21) days	0 810		
0 920 SS=C	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 920		

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0 920	Continued From page 44 a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's Service Plan Agreement dated November 5, 2021, indicated "Service Type" were personal care assistance, assistance with bathing-shower and housekeeping. R1's Assisted Living Contract dated October 18, 2021, lacked the following required content: - a disclosure that it does not hold an assisted living facility with dementia care license; and - a disclosure of the facility's ability to provide specialized diets R2 R2's Service Plan Agreement dated November 6, 2021, indicated "Service Type" were personal care assistance, assistance with bathing-shower, housekeeping and escort one way. R2's Assisted Living Contract dated September 30, 2021, lacked the following required content: - a disclosure that it does not hold an assisted living facility with dementia care license; and - a disclosure of the facility's ability to provide specialized diets On February 17, 2022, at 3:06 p.m. licensed assisted living director (LALD)-A and executive director (ED)-B confirmed R1 and R2's contract lacked the above content. LALD-A and ED-B	0 920		

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0 920	Continued From page 45 verified the licensee contract would lack the same content for all residents. The licensee lacked a policy for Assisted Living Licensure contract requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 930		

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0 930	Continued From page 46 licensee failed to execute a written contract with the required content for two of two residents (R1, R2) 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 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's assisted living contract provided to residents lacked a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who was designated to handle and resolve complaints. R1 R1's Service Plan Agreement dated November 5, 2021, indicated "Service Type" were personal care assistance, assistance with bathing-shower and housekeeping. R2 R2's Service Plan Agreement dated November 6, 2021, indicated "Service Type" were personal care assistance, assistance with bathing-shower, housekeeping and escort one way. R1's Assisted Living Contract was dated October 18, 2021, and R2's Assisted Living Contract was dated September 30, 2021, respectively.	0 930		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 930	Continued From page 47 The licensee's Resident Handbook updated October 2020, indicated "a grievance should be placed in writing to the executive director. The executive director will respond in writing within 30 days with actions that have or will be taken to remedy the situation to satisfaction. If dissatisfaction remains, the resident/representative should submit the grievance in writing to the chief executive officer (CEO). The CEO will investigate and respond in writing within 15 days. If both steps fail to remedy the grievance, the resident/representative is encouraged to contact the Office of Ombudsman for Older Americans at the Minnesota Board of Aging or the Office of Health Facilities Complaints at Minnesota Department of Health." R1 and R2's contract indicated for "Complaint Procedure/Nondiscrimination" questions, concerns and complaints should be "addressed first with the appropriate staff person in charge of the area about which resident(s) has/have a question, concern or complaint. If the matter remains unresolved, resident(s) or resident's responsible person should contact the LALD-IR"; however, the contract did not include the facility's complaint resolution process or the name and contact information of the person designated to handle and resolve complaints as indicated in the resident handbook dated October 2020. On February 17, 2022, at 3:06 p.m. licensed assisted living director (LALD)-A and executive director (ED)-B confirmed R1 and R2's contract lacked the above content. LALD-A and ED-B verified the licensee contract would lack the same for all residents. The licensee lacked a policy for Assisted Living	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30490	A. BUILDING: _____ B. WING _____	02/18/2022

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MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

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0 930	Continued From page 48 Licensure contract requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance	0 940		

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0 940	Continued From page 49 through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2) 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's Service Plan Agreement dated November 5, 2021, indicated "Service Type" were personal care assistance, assistance with bathing-shower and housekeeping. R1's Assisted Living Contract dated October 18, 2021, lacked the following required content: - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b) R2 R2's Service Plan Agreement dated November 6, 2021, indicated "Service Type" were personal	0 940		

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0 940	Continued From page 50 care assistance, assistance with bathing-shower, housekeeping and escort one way. R2's Assisted Living Contract dated September 30, 2021, lacked the following required content: - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b) On February 17, 2022, at 3:06 p.m. licensed assisted living director (LALD)-A and executive director (ED)-B confirmed R1 and R2's contract lacked the above content. LALD-A and ED-B verified the licensee contract would lack the same for all residents. The licensee lacked a policy for Assisted Living Licensure contract requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 970		

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0 970	Continued From page 51 licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 34 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 included: R1's record included a copy of the Assisted Living Contract dated October 18, 2021. R2's record included a copy of the Assisted Living Contract dated September 30, 2021. The Assisted Living Contract included a section for "Liability" and indicated "Provider is not liable to resident for any injury, death or property damage occurring in the apartment or on the providers premises unless such an injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by resident" and "unless caused by one of the aforementioned excepted reasons resident agrees to hold provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrences in the apartment or on provider's premises". On February 17, 2022, at 3:06 p.m. licensed	0 970		

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0 970	Continued From page 52 assisted living director (LALD)-A and executive director (ED)-B confirmed the licensee assisted living contract for all residents included the above content under "Liability". The licensee lacked a policy for Assisted Living Licensure contract requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01370 SS=D	144G.61 Subd. 2 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;	01370		

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01370	Continued From page 53 (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations contained all the required training for one of two unlicensed personnel (ULP-H) 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: ULP-H had a hire date of December 16, 2021. ULP-H provided direct care and services to the licensee residents.	01370		

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01370	Continued From page 54 On February 16, 2022, at approximately 9:13 a.m. ULP-H confirmed she provided direct care and services to residents. ULP-H's record lacked documentation of completed training for the following: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - hair care; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - assisting with toileting; - standby assistance techniques and how to perform them; - medication and treatment reminders; and - awareness of commonly used health technology equipment and assistive devices ULP-H's record lacked documentation of completed competency for the following: - hair care; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - assisting with toileting; and - standby assistance techniques and how to perform them On February 18, 2022, at approximately 9:53 a.m. registered nurse (RN)-C verified ULP-H lacked the required training and demonstrated skill competency for the above topics. The licensee's Assisted Living Orientation ULP Staff policy dated August 1, 2021, indicated the ULP would receive training with written or oral test and skills demonstration for the above topics.	01370		

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01370	Continued From page 55 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-H, ULP-I) 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	01380		

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01380	Continued From page 56	01380		

cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

On February 18, 2021, at approximately 9:38 a.m. registered nurse (RN)-C confirmed ULP-H and ULP-I provided delegated tasks to the licensee's residents for medication administration and treatment and therapy services of oxygen, compression stockings, blood sugar check, orthotic braces, pulse oximeter and continuous positive airway pressure (CPAP).

ULP-H
ULP-H had a hire date of December 16, 2021.

On February 16, 2022, at approximately 9:13 a.m. ULP-H confirmed she provided direct care and services to residents. ULP-H stated she checked the residents' temperature and oxygen saturation daily for COVID-19 screening.

ULP-H's record lacked training and skills demonstration for the delegated tasks of:
- CPAP; and
- orthotic braces

ULP-I
ULP-I had a hire date of January 27, 2015.

On February 16, 2022, at 8:17 a.m. ULP-I was observed to administer oral medications to R1, check R1's blood sugar and administer insulin by insulin pen injection to R1. ULP-I stated she also checked the residents' temperature and oxygen

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01380	Continued From page 57 saturation daily for COVID-19 screening. On February 16, 2022, at 8:58 a.m. ULP-I was observed to administer oral medications to R2. ULP-I's Medication Competency Training for Nursing Assistant Registered dated January 30, 2015, indicated training for the following topics, but lacked documented skills demonstration (evidence of a written procedure and indication of pass or fail for competency evaluations): - medication administration (all routes); and - blood sugar check In addition, ULP-I's record lacked training and skills demonstration for the delegated tasks of: - oxygen; - CPAP; - orthotic braces; - compression stockings; and - pulse oximeter (equipment used to check oxygen saturation level) On February 18, 2022, at approximately 9:38 a.m. RN-C confirmed ULP-H and ULP-I records lacked evidence of training and demonstration of skills competency for the above topics. The licensee's Assisted Living Orientation ULP Staff policy dated August 1, 2021, indicated the ULP would receive training with written or oral test and skills demonstration for administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		

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01450	Continued From page 58	01450		
01450 SS=D	144G.62 Subd. 5 Documentation A facility must retain documentation of supervision activities in the personnel records. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure documentation of direct supervision of staff performing delegated tasks for one of two unlicensed personnel (ULP-H) 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: ULP-H's employee record lacked evidence of documentation of a registered nurse (RN) supervising ULP-H performing delegated tasks. ULP-H was hired on December 16, 2021, to provide direct care services to residents under the assisted living license. On February 16, 2022, at approximately 9:13 a.m. ULP-H confirmed she provided direct care and services to residents. ULP-H's record indicated ULP-H was trained and competency evaluated for delegated tasks of medication administration and treatment services.	01450		

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01450	Continued From page 59 On February 18, 2022, at approximately 9:53 a.m., RN-C stated she had "watched" (conducted supervision) of ULP-H performing delegated tasks "after initial training" for medication and treatment services, but she had not "documented" the direct supervision for observation of the delegated tasks. The licensee's Supervision of Unlicensed Personnel policy dated August 1, 2021, indicated the RN or appropriate licensed health professional would document supervision of staff in the personnel file. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01450		
01470 SS=F	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;	01470		

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01470	Continued From page 60 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss 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.	01470		

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01470	Continued From page 61 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (unlicensed personnel (ULP)-H, ULP-I and registered nurse (RN)-C) 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: ULP-H ULP-H had a hire date of December 16, 2021. On February 16, 2022, at approximately 9:13 a.m. ULP-H confirmed she provided direct care and services to residents. ULP-H stated she checked the residents' temperature and oxygen saturation daily for COVID-19 screening. ULP-H's record lacked documented evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - compliance with and reporting of the	01470		

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maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);
- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
- 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;
-a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and
- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person

ULP-I
ULP-I had a hire date of January 27, 2015.

On February 16, 2022, at 8:17 a.m. ULP-I was observed to administer oral medications to R1, check R1's blood sugar and administer insulin by insulin pen injection to R1.

ULP-I's record lacked documented evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following:
- an overview of this chapter (assisted living statutes);
- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;
- handling of residents' complaints, reporting of

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01470	Continued From page 63	01470		

complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
- 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
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure

RN-C
RN-C had a hire date of November 8, 2021.

RN-C record lacked documented evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following:
- an overview of this chapter (assisted living statutes);
- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;
- handling of emergencies and use of emergency services;
- compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);
- the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;
- handling of residents' complaints, reporting of

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01470	Continued From page 64 complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - 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 - a review of the types of assisted living services the employee will be providing and the facility's category of licensure On February 17, 2022, at 1:17 p.m. RN-C stated she had had some training for assisted living through a consultant by zoom meetings on November 16, 2021, and December 2, 2021 (assisted living bill of rights, initial and continuing assessments, home care statutes 144G 144.08), but had no documented evidence for the training being completed from the consultant. On February 18, 2022, at approximately 9:38 a.m. RN-C confirmed ULP-H and ULP-I's records lacked evidence for the above orientation training. RN-C confirmed she had not completed orientation training for all topics required and her record lacked documented evidence for some of the training completed. The licensee's Assisted Living and Assisted Living with Memory Care Orientation All Staff policy dated August 1, 2021, indicated staff would receive orientation and training on topics required for assisted living and all assisted living employees "must complete" an orientation to assisted living facility licensing requirements and regulations before providing services to residents.	01470		

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01470	Continued From page 65 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure three of	01530		

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01530	Continued From page 66 three employees (unlicensed personnel (ULP)-H, ULP-I and registered nurse (RN)-C) received the required amount of dementia care training, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-H ULP-H was hired on December 16, 2021, to provide direct care services under the licensee's Assisted Living license. On February 16, 2022, at approximately 9:13 a.m. ULP-H confirmed she provided direct care and services to residents. ULP-H's record identified training for dementia topics completed were dated December 19 and 20, 2021, for a total of six hours. ULP-H's record lacked evidence of dementia care training for the topic of person-centered planning and service delivery and a total of eight hours of dementia care training within 160 working hours of ULP-H's employment start date as required. ULP-I ULP-I had a hire date of January 27, 2015. ULP-H provided direct care services under the	01530		

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01530	Continued From page 67 licensee's Assisted Living license effective August 1, 2021. On February 16, 2022, at 8:17 a.m. ULP-I was observed to administer oral medications to R1, check R1's blood sugar and administer insulin by insulin pen injection to R1. ULP-I's record identified the following dementia care training: - abuse prevention in persons with dementia the basics, completed on March 15, 2017, for 0.5 hour; - caring for the Alzheimer's client completed on March 20, 2017, for 1.0 hour; - understanding dementia completed on March 20, 2017, for 0.75 hour; - caring for the Alzheimer's client completed on April 20, 2018, for 1.0 hour; - challenging behaviors:care and interventions for residents experiencing dementia completed on April 19, 2018, for 0.5 hour; and - understanding dementia completed on April 19, 2018, for 0.75 hour ULP-I's record lacked evidence of dementia care training for the required topics for: - an explanation of Alzheimer's disease and other dementia's; - communication skills; and - person-centered planning and service delivery In addition, ULP-I's record lacked evidence for a total of two hours of dementia care training for each 12 months of employment as required. RN-C RN-C was hired on November 8, 2021, to provide supervision of direct care staff under the licensee's Assisted Living license.	01530		

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01530	Continued From page 68 RN-C's record identified the following dementia care training: - dementia a refresher completed on April 16, 2021, for 1.0 hour; and - dementia management and abuse prevention completed on July 30, 2020, for 1.25 hours RN-C's record lacked evidence of dementia care training for the required topics of: - an explanation of Alzheimer's disease and other dementia's; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery In addition, RN-C's record lacked evidence for a total of eight hours of dementia care training within 120 working hours as required. On February 18, 2022, at approximately 9:38 a.m. RN-C confirmed ULP-H and ULP-I records lacked evidence for the above dementia care training as required. RN-C confirmed she had not completed dementia care training as required. The licensee's Assisted Living Dementia Training policy dated August 1, 2021, indicated assisted living staff would receive required training on dementia care during orientation and annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring	01610		

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01610	Continued From page 69 (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment and had proposed a temporary service plan for one of two residents (R1) as required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client'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:	01610		

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01610	Continued From page 70 R1's Assisted Living Contract was dated October 18, 2021. R1's start of care date for services was October 20, 2021. R1's diagnoses included dementia and diabetes. R1's 2021 Uniform Nursing Assessment Tool date was signed October 21, 2021, after R1's Assisted Living Contract was signed on October 18, 2021, instead of prior to the date on which the resident executed the contract with the facility as required. R1's Service Plan Agreement was dated October 20, 2021, but was not signed by the responsible party for R1 until November 5, 2021, and indicated R1 received services which included personal care assistance (dressing in morning and at bedtime, putting on and removal of compression stockings, daily weight), assistance with bathing-shower, housekeeping, blood sugar checks, insulin pen administration and medication management complex. On February 16, 2022, at 1:34 p.m. RN-C confirmed R1's nursing assessment was not completed in the timeframe required. The licensee's Initial and On-Going Nursing Assessment of Residents under the Comprehensive Licensed Agency policy dated August 1, 2021, indicated nursing assessments were completed based upon the required assessment schedule and the director of health services would complete a pre-admission assessment.	01610		

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01610	Continued From page 71 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=H	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) had completed and/or documented a comprehensive assessment for change in	01620		

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01620	Continued From page 72	01620		

condition for three of three residents (R4, R2, R1) related to falls. In addition, the licensee failed to ensure the RN conducted ongoing client monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R2, R1) with records reviewed.

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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R4
R4's record lacked evidence the RN had conducted an assessment of the resident for a change in condition related to falls and ER visit following falls, including assessment for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury.

R4's diagnoses included congestive heart failure and vascular dementia with behavioral disturbance.

R4's Service Plan effective date February 17, 2022, unsigned, indicated R4 received services which included personal care assitance (putting on socks and braces, dressing, remake bed with clean linens, assist with bedtime cares, assist with toileting, remove and wash TEDS

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01620	Continued From page 73 (compression socks) daily), assistance with bathing-shower, housekeeping, laundry and documenting resident's blood pressure. R4's record included the following Resident Incident/Accident Report and Progress Notes: -October 16, 2021, at 9:15 a.m. found on floor in bathroom, no injury. R4 stated she lost her balance and fell backwards. -October 20, 2021, at 6:15 p.m. found on floor. R4 stated she was reaching for basket of books and fell backwards hitting head on the carpet. -October 21, 2021, at 9:40 a.m. found on floor in bathroom. R4 stated she was trying to use the bathroom, she doesn't remember. R4 stated she hit her head. Bruise on the back of her left hand. R4 was sent to the hospital. -October 25, 2021, at 3:50 p.m. found on the floor in the living room. R4 stated when she turned to sit, she lost her balance and fell. -Progress Note dated October 28, 2021, indicated late entry for October 21, 2021, for resident fall and fall on October 21, 2021. The note indicated R4 hit her head and was sent to the ER for evaluation due to hitting her head and taking coumadin (blood thinner medication). R4 returned to the facility with no concerns and no changes. Vitals were documented. -November 23, 2021, at 2:45 a.m. found on the floor in the bedroom. R4 stated she was standing from her bed, the walker moved and she fell to floor on her knees. -January 8, 2022, at 9:40 p.m. found on the floor in the living room. R4 stated, "I fell." -January 19, 2022, at 12:50 p.m. found on the floor in the bathroom. R4 stated she was reaching for toilet paper in the closet, her knee gave out, and she fell. -January 27, 2022, at 9:10 a.m. found on the floor in the living room. R4 stated she fell reaching for	01620		

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01620	Continued From page 74 a book. -January 30, 2022, at 12:50 p.m. found on the floor in the living room. R4 stated she was reaching for books and her leg gave out. R4's record lacked evidence of documented assessment by the RN for change in condition related to the falls and ER visit as above, including review for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury. R2 R2's record indicated a start of care date of September 30, 2021. R2's diagnoses included congestive heart failure and chronic kidney disease stage three. 90 DAY ASSESSMENT R2's record lacked assessment by the RN not to exceed 90 calendar days from the last date of the assessment. R2's record indicated the assessments by the RN were completed as follows: - September 30, 2021; - October 14, 2021; and - February 7, 2022 (106 days) CHANGE IN CONDITION ASSESSMENT R2's record lacked evidence the RN had conducted an assessment of the resident for change in condition related to falls and ER visit following falls, including an assessment for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury.	01620		

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01620	Continued From page 75 R2's Service Plan Agreement was dated September 30, 2021, and signed by R1's responsible party on November 6, 2021, indicated R2 received services which included personal care assistance (putting on and removal of compression stockings, make bed daily), assistance with bathing-shower, housekeeping, escorts and medication management complex. R2's record included the following Resident Incident/Accident Report and Progress Notes: - December 13, 2021, at 10:15 p.m. found on floor in kitchen, bruise noted next day. R2 did not remember what happened. - February 1, 2022, at 9:05 a.m. found on the floor in the bedroom, bruising was noted. R2 stated she was trying to reach the bed after using the bathroom. - Progress Note dated February 1, 2022, R2 was seen in the ER on January 31, 2022, and returned to the facility on February 1, 2022. RN assessed the resident; however, there was no documented evidence for review of causative factors or interventions implemented related to the fall. -February 10, 2022, at 9:20 a.m. witnessed fall in bedroom. R2 lost her balance and tipped backward, no injuries. R2's record lacked evidence of a documented assessment by the RN for a change in condition related to the falls and ER visit as above, including review for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury. R1	01620		

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	30490	A. BUILDING: _____ B. WING _____	02/18/2022

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01620	Continued From page 76 R1's record indicated a start of care date of October 20, 2021. R1's diagnoses included dementia and diabetes. 90 DAY ASSESSMENT R1's record indicated the RN completed the following assessments: - October 21, 2021; and - November 4, 2021 R1's record lacked assessment by the RN not to exceed 90 calendar days from the last date of the assessment on November 4, 2021 (102 days). CHANGE IN CONDITION ASSESSMENT R1's record lacked evidence the RN had conducted an assessment of the resident following falls to assess for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury, and following being sent to the hospital. R1's Service Plan Agreement dated November 5, 2021, indicated R1 received services which included personal care assistance (assistance with a.m. and bedtime cares/"ADLs" (activities of daily living), putting on and removal of compression stockings, daily weight), assistance with getting continuous positive airway pressure (CPAP) machine set up and on at bedtime, assistance with bathing-shower, assistance with putting on and removal of lymphedema (swelling in arm or leg caused by lymphatic system blockage) compression device twice daily, housekeeping, blood sugar checks, insulin pen administration and medication management complex. R1's record included the following Resident	01620		

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01620	Continued From page 77 Incident/Accident Reports: - January 15, 2022, at 9:00 p.m. fall in bathroom, head hit the wall left side. Emergency medical services called and resident was transported to the hospital. Resident reported just finished using bathroom and lost her balance on the way out to the bedroom. - January 17, 2022, at 8:20 [did not indicate if a.m. or p.m.] found on the floor in the apartment, abrasion on left arm with bruising. Resident stated she was picking out clothes to wear. R1's record lacked evidence of documented assessment by the RN for change in condition related to the falls as above, including review for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury. On February 16, 2022, at 1:10 p.m. RN-C confirmed R4, R2 and R1's records lacked evidence of assessment by the RN for change in condition following falls to assess for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury and following visits to the ER. RN-C stated since she started working for the licensee (November 8, 2021), changes had been made with R4's blood pressure medication, R4 was on physical therapy, toilet paper was moved within reach and braces for R4's legs had been requested to be brought back, which a family member had removed; however, there was no evidence of assessments or interventions from each fall to prevent potential harm from occurring. On February 16, 2022, at 1:34 p.m. RN-C confirmed R1 and R2's records lacked RN assessments not to exceed 90 calendar days	01620		

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01620	Continued From page 78 from the last date of the assessment. The licensee's Initial and On-Going Nursing Assessment of Residents under the Comprehensive Licensed Agency policy dated August 1, 2021, indicated nursing assessments were completed based upon the required assessment schedule and as needed based upon resident condition. The director of health services or RN would complete a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs as required for change in resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01630 SS=D	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to initiate a temporary service plan 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	01630		

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01630	Continued From page 79	01630		

cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's diagnoses included dementia and diabetes.

R1's start of care date for services was October 20, 2021.

On February 16, 2022, at 8:17 a.m. unlicensed personnel (ULP)-I was observed to administer oral medications to R1, check R1's blood sugar and administer insulin by insulin pen injection to R1.

R1's 2021 Uniform Nursing Assessment Tool was signed as completed on October 21, 2021. The assessment was not completed prior to initiation of services on October 20, 2021.

R1's Service Plan Agreement was dated October 20, 2021, and signed by R1's responsible party on November 5, 2021, indicated R1 received services which included personal care assistance (dressing in morning and at bedtime, putting on and removal of compression stockings, daily weight), assistance with bathing-shower, housekeeping, blood sugar checks, insulin pen administration and medication management complex.

R1's record lacked evidence a temporary service plan was completed with the resident at the time services were initiated by the facility as required.

On February 16, 2022, at 1:34 p.m. RN-C

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01630	Continued From page 80 confirmed R1's record lacked a temporary service plan as required. A policy for service plans was requested, but not provided. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01630		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced	01640		

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01640	Continued From page 81 by: Based on interview and record review, the licensee failed to finalize a current written service plan within 14 calendar days 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: R1 R1's record lacked a finalized service plan no later than 14 calendar days after the date that services were first provided and lacked evidence of revision of the service plan with change in services. R1's record indicated R1's start of care date was October 20, 2021. R1's diagnoses included, but were not limited to, dementia and diabetes. R1's Service Plan Agreement was dated October 20, 2021, but was not signed by the responsible party for R1 until November 5, 2021, and indicated R1 received services which included personal care assitance (dressing in morning and at bedtime, putting on and removal of compression stockings, daily weight), assistance with bathing-shower, housekeeping, blood sugar checks, insulin pen administration and medication	01640		

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01640	Continued From page 82	01640		

management complex. The service plan failed to be finalized no later than 14 days after services were first provided on October 20, 2021.

REVISION OF SERVICE PLAN
R1's Service Plan Agreement dated November 5, 2021, indicated R1 received services which included personal care assitance (assistance with a.m. and bedtime cares/"ADL's" (activities of daily living), putting on and removal of compression stockings, daily weight), assistance with getting continuous positive airway pressure (CPAP) machine set up and on at bedtime, assistance with bathing-shower, assistance with putting on and removal of lymphedema (swelling in arm or leg caused by lymphatic system blockage) compression device twice daily, housekeeping, blood sugar checks, insulin pen administration and medication management complex.

On February 16, 2022, at 9:15 a.m. R1 stated she was able to dress herself, put on and remove compression stocking, CPAP and lymphedema compression wrap device without assistance.

On February 16, 2022, at approximately 9:13 a.m. ULP-I stated R1 was able to "dress herself," put on and remove compression stockings and lymphedema compression wraps "by herself" and staff "assist with CPAP as needed." ULP-I stated R1 had "been doing" this for a "couple months now."

On February 16, 2022, at 10:02 a.m. RN-C was observed to check R1's INR (international normalized ratio/a test that measures the time for the blood to clot).

R1's Service Delivery Record for February 2022, indicated staff were signing for providing the

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01640	Continued From page 83 services of "assistance with bathing-shower, beauty shop, personal care assistance, Housekeeping (included) and "FYI" [for your information/information about R1] to NARs [nursing assistance registered]." R1's service plan lacked revision with changes to services being provided. R2 R2's record lacked a finalized service plan no later than 14 calendar days after the date that services were first provided and lacked evidence of revision of the service plan with change in services. R2's record indicated a start of care date was September 30, 2021. R2's diagnoses included congestive heart failure and chronic kidney disease stage three. R2's Service Plan Agreement was dated September 30, 2021, but was not signed by the responsible party for R1 until November 6, 2021, and indicated R2 received services which included personal care assitance (putting on and removal of compression stockings, make bed daily), assistance with bathing-shower, housekeeping, escorts and medication management complex. The service plan failed to be finalized no later than 14 days after services were first provided on September 30, 2021. REVISION OF SERVICE PLAN On February 16, 2022, at approximately 8:49 a.m. ULP-I stated in addition to medication administration, R2 required "assistance with dressing," was "in bed at all times now" and required "repositioning every two hours,"	01640		

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01640	Continued From page 84 assistance with "oxygen" use, and assistance with "toileting using a bedpan." In addition, R2 "no longer wore" compression stockings. R2's physician orders indicated effective on February 11, 2022, discontinue compression socks daily. R2's Service Delivery Record for February 2022, indicated staff were signing for providing the services of "assistance with bathing-Spa, escort one way, personal care assistance, Housekeeping (included) and "FYI" [for your information] to NARs [nursing assistance registered]." R2's service plan lacked revision with changes to services being provided. On February 16, 2022, at 1:34 p.m. RN-C confirmed R1 and R2's service plan failed to be finalized no later than 14 days after services were first provided and lacked revision with changes in services. A policy for service plans was requested, but not provided. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each	01650		

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01650	Continued From page 85 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 (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	01650		

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01650	Continued From page 86 of the residents). The findings include: R1 R1's Service Plan Agreement dated November 5, 2021, indicated R1 received services which included personal care assistance (assistance with a.m. and bedtime cares/"ADLs" (activities of daily living), putting on and removal of compression stockings, daily weight), assistance with getting continuous positive airway pressure (CPAP) machine set up and on at bedtime, assistance with bathing-shower, assistance with putting on and removal of lymphedema (swelling in arm or leg caused by lymphatic system blockage) compression device twice daily, housekeeping, blood sugar checks, insulin pen administration and medication management complex. The service plan also addressed "Code Status" and indicated the "RN [registered nurse] will reassess the client in person and update the service plan based on the client's needs and at a frequency not to exceed 90 days from the last assessment." On February 16, 2022, at 8:17 a.m. unlicensed personnel (ULP)-I was observed to administer oral medications to R1 from a pre set-up medication dosage box, check R1's blood sugar and administer insulin by injection to R1. On February 16, 2022, at 10:02 a.m. RN-C was observed to check R1's INR (international normalized ratio/a test that measures the time for the blood to clot). R1's Service Plan lacked the service of INR check by the RN, including the frequency of the service and fee for the service, and lacked	01650		

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01650	Continued From page 87 identification of staff or categories of staff who would provide the service for blood sugar checks, insulin pen administration and medication management complex. In addition, the service plan lacked the schedule and methods of monitoring assessments of the resident (for initial, 14 day, change in condition), a contingency plan that included 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 ("Advance Directives" on the service plan was not addressed). R2 R2's Service Plan Agreement was dated September 30, 2021, but was not signed by the responsible party for R1 until November 6, 2021. The service plan indicated R2 received services which included personal care assistance (putting on and removal of compression stockings, make bed daily), assistance with bathing-shower, housekeeping, escorts and medication management complex. The service plan also addressed "Code Status" and indicated the "RN will reassess the client in person and update the service plan based on the client's needs and at a frequency not to exceed 90 days from the last assessment." On February 16, 2022, at approximately 8:49 a.m. ULP-I stated in addition to medication administration, R2 required "assistance with dressing," was "in bed at all times now" and required "repositioning every two hours," assistance with "oxygen" use, assistance with "toileting using a bedpan" and R2 "no longer wore" compression stockings.	01650		

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01650	Continued From page 88 On February 16, 2022, at 8:58 a.m. ULP-I was observed to administer oral medications to R2. R2's Service Plan lacked the services of assistance with dressing, repositioning every two hours, assistance with oxygen use and toileting using a bedpan, identification of staff who would provide the services, the frequency and fee of the services and lacked identification of staff or categories of staff who would provide the service for medication management complex. In addition, the service plan lacked the schedule and methods of monitoring assessments of the resident (for initial, 14 day, change in condition), a contingency plan that included 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 ("Advance Directives" on the service plan was not addressed). On February 16, 2022, at 1:34 p.m. RN-C confirmed R1 and R2's service plan lacked the above information. RN-C stated all residents being provided services would lack the schedule and methods of monitoring assessments of the resident and identification of and information as to who has authority to sign for the resident in an emergency. The licensee's policy for service plans was requested, but not provided. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21)	01650		

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01650	Continued From page 89 days	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced	01690		

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	30490	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

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01690	Continued From page 90 by: Based on observation, interview, and record review, the licensee failed to ensure the the accountability of controlled substances and failed to ensure medication management policies and procedures were developed under the supervision and direction of a registered nurse (RN), licensed health professional, or pharmacist consistent with current practice standards. In addition, the licensee failed to ensure medication errors were investigated and corrective actions were documented for two of three residents (R2, R5) 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 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: CONTROLLED MEDICATION The licensee lacked evidence of maintaining accountability of controlled medications being stored in a medication storage room. On February 18, 2022, at 8:24 a.m. observation of the medication storage room with registered nurse (RN)-C identified a locked compartment inside of the locked medication storage room which contained a bottle of lorazepam 0.5 milligrams (five tablets total) and an opened bottle of Morphine Sulfate oral solution 100 mg/(per) 5 milliliters (ml) with 30 ml of medication remaining. The bottle of lorazepam identified the medication	01690		

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01690	Continued From page 91 had a dispense date of November 5, 2021, and the Morphine had a dispense date of November 4, 2021. RN-C stated the Morphine bottle had medication removed to pre-fill 10 syringes of medication which were now located in the licensee's medication cart for administration of the medication by the unlicensed personnel. RN-C confirmed there was no documented information for consistent accountability for diversion of the medications. MEDICATION POLICY AND PROCEDURE The licensee's medication policy and procedures provided were Renewal of Medication, Treatment or Therapy Prescriptions and Orders; Requesting and Receiving Medication Prescriptions and Refills; Medication, Treatment and Therapy Reminders; Administration and Documentation of PRN Medications; Administration of Medication, Treatment and Therapy by Unlicensed Personnel; Administration of Oral Medications; Administration of Rectal Medications; Medication Errors; Documentation of Medication, Treatment and Therapy Management Services; Monitoring of Clients and Their Services; Storage of Medications and Safe Medication Management. The policy and procedures were documented as reviewed and revised by licensed assisted living director (LALD)-A on August 1, 2021, or had no documented information for "Effective Date," "Reviewed By" or "Revised By" or was documented "Approved: Policy Review Committee." On February 16, 2022, at 1:00 p.m. executive director (ED)-B verified the persons involved in development of the above policy and procedures for medication management services were not registered nurses.	01690		

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01690	Continued From page 92 On February 16, 2022, at 2:02 p.m. LALD-A verified he was documented as the person to have reviewed and revised the above policy and procedures for medication management services. LALD-A confirmed the licensee's policy and procedures for medication management services were not developed under the supervision and direction of a registered nurse. On February 18, 2022, at 9:49 a.m. RN-C confirmed she had not addressed or developed any policy and procedures for medication management services. MEDICATION ERRORS The licensee's Medication/Treatment Error Reports indicated the following: -January 24, 2022, R2 was not administered xtampza (used for pain) 9 milligrams (mg) as ordered. Attached to the report was a copy of the medication bubble card and the pharmacy label indicated take one capsule by mouth twice daily. The report lacked documented review by the nurse for outcome to the resident for "no harm, increase monitoring, meds or hospitalization" and documented "recommendations to prevent future errors" as indicated on the report. -January 31, 2022, R5 was not administered clonazepam (used to control seizures) 0.25 mg for two doses. R5's prescription dated January 27, 2022, indicated to give 0.25 mg three times a day for anxiety. The report lacked documented review by the nurse for outcome to the resident for "no harm, increase monitoring, meds or hospitalization" and documented "recommendations to prevent future errors" as indicated on the report. On February 15, 2022, at 11:57 a.m. RN-C	01690		

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01690	Continued From page 93 confirmed the medication error reports lacked documented outcome to the residents and education for the medication errors had not been completed. The licensee's Storage of Medications policy dated August 1, 2021, indicated medications will be handled and stored per acceptable standards and the RN would establish a system that addresses the storage and handling of medications, including controls and procedures to identify or prevent diversion of medications. The licensee's Medication Errors policy dated August 1 2021, indicated the RN would immediately investigate any medication errors and would implement and document corrective actions to reduce the risk of similar medication errors in the future and the RN would determine the potential harm to the client. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face	01700		

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01700	Continued From page 94 with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided, and how the services would be provided 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).	01700		

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01700	Continued From page 95 The findings include: R1 R1's diagnoses included dementia and diabetes. On February 16, 2022, at 8:17 a.m. unlicensed personnel (ULP)-I was observed to administer oral medications and insulin by an insulin pen injection to R1. R1's Service Plan Agreement dated November 5, 2021, indicated R1 received services which included insulin pen administration and medication management complex. R1's Medication Sheet dated February 2022, indicated R1 received four medications used to treat high blood pressure, two used to treat diabetes, one to prevent blood clots, one used to treat dementia, one used to reduce cholesterol, one used for insomnia, one used to treat wheezing/shortness of breath (SOB), one used to treat chest pain, one used for pain, one used to treat under active thyroid gland, one multivitamin and one used to reduce fluid retention. R1's 2021 Uniform Nursing Assessment Tool dated November 4, 2021, indicated "Medications" review of over the counter, herbal and prescribed medications include dose, frequency, route, prescriber, reason used and pharmacy "See attached copy"; however, no further information was provided. The assessment further indicated services needed were "administration of medications/central storage of medication" and "facility will store, maintain, and administer all medication to prevent diversion of medications." R1's record lacked an assessment prior to providing medication management services by	01700		

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01700	Continued From page 96	01700		

the RN, to include the following:
- documentation the assessment was conducted face-to-face with the resident; and
- identification and review of all medications the resident is known to be taking, which included indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues

R2
R2's diagnoses included congestive heart failure and chronic kidney disease stage three.

On February 16, 2022, at 8:58 a.m. ULP-I was observed to administer oral medications to R2.

R2's Service Plan Agreement was dated September 30, 2021, but was not signed by the responsible party for R1 until November 6, 2021, and indicated R2 received services which included medication management complex.

R2's Medication Sheet dated February 2022, indicated R2 received one medication for pain/shortness of breath (SOB), two used to reduce fluid retention, one to treat dry eyes, one used to reduce secretions, one used to treat under active thyroid gland, three used to treat constipation, one used for anxiety, and one used for agitation.

R2's 2021 Uniform Nursing Assessment Tool dated October 14, 2021, indicated "Medications," review of over the counter, herbal and prescribed medications include dose, frequency, route, prescriber, reason used and pharmacy "See attached copy"; however, no further information was provided. The assessment further indicated services needed were "administration of medications/central storage of medication" and

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01700	Continued From page 97 "facility will store, maintain, and administer all medication to prevent diversion of medications". R2's record lacked an assessment prior to providing medication management services by the RN, to include the following: - documentation the assessment was conducted face-to-face with the resident; and - identification and review of all medications the resident is known to be taking, which included indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues On February 16, 2022, at 1:34 p.m. RN-C confirmed R1 and R2's records lacked a medication assessment for the above content prior to providing medication management services. The licensee's Initial and On-Going Nursing Assessment of Residents under the Comprehensive Licensed Agency policy dated August 1, 2021, indicated the director of health services or RN would complete a comprehensive assessment which included, but may not be limited to the requirements outlined by Minnesota rules. Comprehensive assessment would include medication review to include identification and review of all medications the resident is known to be taking, which included indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

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01730	Continued From page 98	01730		
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 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	01730		

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01730	Continued From page 99 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 an individualized medication management plan to include 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, 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 R1's Service Plan Agreement dated November 5, 2021, indicated R1 received insulin pen administration and medication management complex services. On February 16, 2022, at 8:17 a.m. unlicensed personnel (ULP)-I was observed to administer oral medications to R1, which were pre set-up into a medication dosage box and administer insulin by insulin pen injection to R1. The medication dosage box had a piece of tape attached on the box with written information of time for administration, medication names and	01730		

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01730	Continued From page 100 "do not crush" written by the medication isosorbide (used to treat angina/chest pain). R1's Medication Sheet dated February 2022, indicated R1 received three medications used to treat high blood pressure, two used to treat diabetes, one to prevent blood clots, one used to treat dementia, one used to reduce cholesterol, one used for insomnia, one used to treat wheezing/shortness of breath (SOB), two used to treat chest pain, one used for pain, one used to treat under active thyroid gland, one multivitamin and one used to reduce fluid retention. R1's Client Individual Medication Management Plan was dated October 20, 2021. The plan indicated "more details will be found on the client's individualized medication record or "MAR" along with details about medications, dosage, storage and route". The plan failed to indicate the licensee was providing the services of medication set-up by the registered nurse (RN) and ULP was providing the service of insulin administration by injection, failed to indicate the licensee was storing R1's medications in a locked medication cart or refrigerator, failed to indicate procedures for staff to notify the the registered nurse (RN) when a problem arises for the administration of warfarin (prevents blood clots) and as needed (PRN) nitroglycerin (used to treat chest pain) medications. In addition, R1's medication sheet lacked instruction "do not crush" for the administration of isosorbide as indicated on R1's medication management plan. R2 R2's Service Plan Agreement was dated September 30, 2021, but was not signed by the responsible party for R1 until November 6, 2021. The service plan indicated R2 received	01730		

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01730	Continued From page 101 medication management complex services. On February 16, 2022, at 8:58 a.m. ULP-I was observed to administer oral medications to R2. R2's Medication Sheet dated February 2022, indicated R2 received one medication for pain/shortness of breath (SOB), two used to reduce fluid retention, one to treat dry eyes, one used to reduce secretions, one used to treat under active thyroid gland, three used to treat constipation, one used for anxiety, and one used for agitation. R2's record lacked an individual medication management plan to include the following: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - 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.	01730		

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01730	Continued From page 102 On February 16, 2022, at 1:34 p.m. RN-C confirmed R1's individual medication management plan lacked the above content and R2's record lacked an individual medication management plan. The licensee's Delegation of Nursing Tasks policy dated August 8, 2021, indicated the RN would complete an assessment of the resident and determine need for nursing services. The RN may delegate medication administration to unlicensed personnel only after the RN had developed specific written instructions for each resident and documented those instructions in the resident's medication record/MAR. The licensee's Safe Medication Management policy dated January 2022, indicated unopened insulin was to be stored in the refrigerator. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel	01750		

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01750	Continued From page 103 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 delegated procedures were followed and the registered nurse (RN) specified, in writing, specific instructions for two of two residents (R1, R2) for administration of medications and one of two unlicensed personnel (ULP-I) was instructed in the proper methods and had demonstrated the ability to competently follow the procedures, 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 R1's Service Plan Agreement dated November 5, 2021, indicated R1 received services which included insulin pen administration and medication management complex. On February 16, 2022, at 8:17 a.m. ULP-I administered oral medications to R1, which were pre set-up into a medication dosage box, and insulin by insulin pen injection. R1's Medication Sheet dated February 2022, indicated "daily weight, record value and report a	01750		

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01750	Continued From page 104	01750		

weight gain of 3# [three pounds] in one day or 5# [five pounds] in past 7 [seven] days to RN promptly." Weights documented included 120 pounds on February 3, 2022, and 123 pounds on February 4, 2022 (three pounds in one day), 123 pounds on February 14, 2022, and 126 pounds on February 15, 2022 (three pounds in one day). R1's record lacked documentation the RN had been notified of the three pound weight increases in one day.

R2
R2's Service Plan Agreement was dated September 30, 2021, but was not signed by the responsible party for R1 until November 6, 2021, and indicated R2 received services which included medication management complex.

On February 16, 2022, at 8:58 a.m. ULP-I was observed to administer oral medications to R2.

R2's Medication Sheet dated February 2022, indicated R2 received two medications to reduce fluid retention. The sheet further indicated "daily weight prior to breakfast and meds [medications], weigh resident daily in A.M. Reports to RN a weight gain of 3# in a day or 5# within a 7 [seven] day period. Weigh client daily on the same scale. Weigh before breakfast and meds." The sheet lacked documented weights daily as directed after February 6, 2022. In addition, the sheets included three as needed (PRN) medications for constipation, but lacked specific instructions for parameters of which medication to administer first for constipation, lacked parameters for administration of PRN anxiety medication (non-medication interventions to try before administration) and lacked parameters (which to administer first) for PRN administration of lorazepam (used for anxiety) and haloperidol

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01750	Continued From page 105 (used for agitation, restlessness/psychosis) medications. ULP DEMONSTRATED COMPETENCY ULP-I had a hire date of January 27, 2015. ULP-I's Medication Competency Training for Nursing Assistant Registered dated January 30, 2015, indicated training for the following topics, but lacked documented skills demonstration (evidence of a written procedure and indication of pass or fail for competency evaluations): -medication administration (all routes) On February 16, 2022, at 1:34 p.m. RN-C confirmed she had not been notified of the 3# weight increases as directed for R1. RN-C verified R2's record lacked documented weights daily as directed. RN-C stated R2 was no longer being weighed daily. RN-C confirmed R2's record lacked parameters for PRN medications. On February 18, 2022, at approximately 9:38 a.m. RN-C confirmed ULP-I's record lacked evidence for demonstration of skills competency for medication administration. The licensee's Delegation of Nursing Tasks policy dated August 8, 2021, indicated the RN may delegate medication administration to unlicensed personnel only after the RN had developed specific written instructions for each resident and documented those instructions in the resident's medication record/MAR. The RN would provide supervision appropriate for the task. The licensee's Administration and Documentation of PRN Medications policy dated August 1, 2021, indicated PRN medications would be administered consistent with parameters	01750		

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01750	Continued From page 106 specified in the prescriber's prescription and with procedures identified by the director of health services or RN for the administration and documentation of the PRN. The licensee's Assisted Living Orientation ULP Staff policy dated August 1, 2021, indicated the ULP would receive training with written or oral test and skills demonstration for administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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 prescriptions for medications were transcribed accurately for	01760		

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01760	Continued From page 107 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 physician Progress Note dated February 10, 2022, included an order for acetaminophen (Tylenol) 500 milligrams (mg) one tablet by mouth three times a day as needed (not to exceed 4000 mg from all sources in 24 hours). On February 16, 2022, at 8:17 a.m. unlicensed personnel (ULP)-I was observed to administer oral medications to R1 and insulin by insulin pen injection. R1's Medication Sheet dated February 2022, indicated "Tylenol Extra Strength 500 mg. Give one tablet as needed for pain." The sheet lacked direction for "three times a day" and "(not to exceed 4000 mg from all sources in 24 hours)" as directed per the prescription order. On February 16, 2022, at 1:34 p.m. registered nurse (RN)-C confirmed R1's prescription for Tylenol was not transcribed accurately as per prescription order. The licensee's, undated, Requesting and Receiving Medication Prescriptions and Refills policy indicated the RN was responsible for	01760		

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01760	Continued From page 108 assuring changes in orders were addressed in the client's Medication Administration Record. 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 one of one resident (R1) with record 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 medication setup in a medication dosage box was completed at the time of setup.	01770		

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01770	Continued From page 109 On February 16, 2022, at 8:17 a.m. unlicensed personnel (ULP)-I was observed to administer oral medications to R1. The medications had been pre-set up into a weekly medication dosage box. The medication dosage box had the names of the medications to be given at 8:00 a.m. written on the side of the dosage box. The medications listed were carvedilol (used to treat high blood pressure), hydralozine (used to treat high blood pressure), levothyroxine (used to treat underactive thyroid gland), lisinopril (used to treat high blood pressure), memantine (used to treat Alzheimer's disease), metformin (used to treat diabetes), multivitamin and torsemide (used to treat fluid retention). On February 16, 2022, at 7:54 a.m. registered nurse (RN)-C confirmed she had setup R2's medications in the medication dosage box. RN-C verified there was "no documentation" for the setup of the medications. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated August 1, 2021, indicated staff will document each task immediately after the tasks has been performed. The policy did not address pre-set up of medications into a medication dosage box. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will	01780		

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01780	Continued From page 110 (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement policies and procedures for giving accurate and current medications for those residents who received medication management services during planned time away from home. This has 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 Delegation of Medications to be Given to Residents by Unlicensed Staff for Residents Time Away From Home policy dated August 1, 2022, indicated "Obtain medications for the planned LOA" (leave of absence).	01780		

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01780	Continued From page 111 The policy failed to address as required for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice. On February 17, 2022, at 12:50 p.m. registered nurse (RN)-C stated, "Yes, staff were allowed to send medications with residents if the RN was not available." RN-C stated staff were to place the medications in an envelope. On February 18, 2022, at 9:38 a.m. RN-C confirmed the licensee's policy above failed to address for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01780		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and	01790		

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01790	Continued From page 112 (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the	01790		

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01790	Continued From page 113	01790		

completion of this task to verify that this task was completed accurately by the unlicensed personnel; and
(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for unplanned time away from home, and failed to ensure two of two unlicensed personnel (ULP-H, ULP-I) were trained and had demonstrated competency to prepare and give medications for clients having unplanned time away. 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:

UNPLANNED TIMES AWAY POLICY AND PROCEDURE
The licensee's Delegation of Medications to be Given to Residents by Unlicensed Staff for Residents Time Away From Home policy dated August 1, 2022, indicated the licensee would provide the necessary medications, education, instructions and support to meet the resident's

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01790	Continued From page 114 medication needs when they are away from home if the licensee provides assistance with self-administration of medication, administration or storage of medications. Only unlicensed staff that have been trained and have satisfactorily demonstrated competency would be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for unplanned leave of absence, not to exceed seven (7) days of medications. The policy further indicated "(special instructions may include the need for the licensed nurse to talk to the resident or resident's representative, instructions for storage, or for controlled substances);" however, the policy did not address providing written information for special instructions as required. The licensee's policy lacked a written procedure to include: - for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence - the resident must be provided written information, including any special instructions for administering or handling the medications, including controlled substances - the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: - the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and	01790		

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01790	Continued From page 115 - the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - how the unlicensed staff must document in the resident's record the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; and - a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel TRAINING AND COMPETENCY EVALUATIONS ULP-H had a hire date of December 16, 2021. ULP-I had a hire date of January 27, 2015. ULP-H and ULP-I's records lacked documented evidence for training and demonstrated competency to prepare and provide medications to residents for unplanned times away from home. On February 17, 2022, at 12:50 p.m. RN-C stated, "Yes, staff were allowed to send medications with residents if the RN was not available." RN-C stated staff were to place the medications in an envelope. On February 18, 2022, at approximately 9:38 a.m. RN-C confirmed ULP-H and ULP-I's records	01790		

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01790	Continued From page 116 lacked evidence of training and demonstration of skills competency for the above treatments or therapy delegated tasks. RN-C confirmed the licensee's policy failed to address the above content. The licensee's Assisted Living Orientation ULP Staff policy dated August 1, 2021, indicated the ULP would receive training with written or oral test and skills demonstration for administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910		

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01910	Continued From page 117 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication to include the medication's strength for one of one discharged resident (R3) with record 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: R3 was discharged on October 5, 2021. R3's Progress Notes dated October 5, 2021, indicated resident was discharged from the licensee with his family member, and the family member was given all of R3's medications. R3's Medication Sheet dated October 2021, identified unlicensed personnel administered R3's medications. R3's Medication Disposition/Disposal Record dated October 5, 2021, identified the following medications were transferred with R3 upon discharge: Tylenol (used for pain), Eliquis (used to prevent blood clots), potassium chloride (used to prevent low blood potassium), propafenone (used to prevent irregular heartbeat), Vitamin D3,	01910		

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	30490	A. BUILDING: _____ B. WING _____	02/18/2022

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01910	Continued From page 118 tab a vite (vitamin), sertraline (used to treat depression), pantoprazole (used to reduce stomach acid), furosemide (used to reduce fluid), verapamil (used to treat high blood pressure), fiber (laxative), morphine (used to relieve pain), lorazepam (used to treat anxiety), bisacodyl suppositories (used for constipation), prochlorper (used for nausea), Tylenol suppository (used for pain/fever), hyoscyamine (used to reduce secretions), haloperidol (used to feel less nervous), artificial tears, albuterol sulfate (Proair) inhaler (used to open and relax air passages to the lungs), Proair inhaler and Ipratropium/albuterol (used to prevent difficulty breathing). The disposition record identified the date, medication name, prescription number, quantity, method of disposition and name of staff involved in the disposition were documented; however, the medication strength was not documented. On February 15, 2022, at 12:38 p.m. registered nurse (RN)-C verified R3's disposition record lacked documentation as noted above. The licensee's Safe Medication Management policy dated January 2022, indicated for "Medication Destruction" the contents to be disposed of should be documented on either form "Disposal of Narcotic Medications" or form "Disposal of Non-Narcotic Medications." The policy did not address upon termination of service to include documentation in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 119 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the policy and procedures for treatments and therapy management services included all the required content and written treatment or therapy management policies and procedures were developed under the supervision and direction of a registered nurse (RN), licensed health professional, or pharmacist consistent with current practice standards, with records reviewed.	01930		

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01930	Continued From page 120 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: The licensee lacked treatment or therapy management policy and procedures for requesting and receiving orders or prescriptions for treatments or therapies and educating and communicating with residents about treatments or therapies they are receiving. The licensee's treatment or therapy management policies and procedures provided were Renewal of Medication, Treatment or Therapy Prescriptions and Orders; Medication, Treatment and Therapy Reminders; Administration of Medication, Treatment and Therapy by Unlicensed Personnel and Documentation of Medication, Treatment and Therapy Management Services. The policy and procedures were documented as reviewed and revised by licensed assisted living director (LALD)-A on August 1, 2021 or had no documented information for "Effective Date", "Reviewed By" or "Revised By". On February 16, 2022, at 1:00 p.m. executive director (ED)-B verified the persons involved in development of the above policy and procedures for treatment or therapy management services	01930		

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01930	Continued From page 121 were not registered nurses. On February 16, 2022, at 2:02 p.m. LALD-A verified he was documented as the person to have reviewed and revised the above policy and procedures for treatment or therapy management services. LALD-A confirmed the licensee policy and procedures for treatment or therapy management services were not developed under the supervision and direction of a registered nurse. On February 17, 2022, at 2:20 p.m., ED-B stated he had provided the policy and procedures the licensee had. ED-B stated if the policy and procedure was not included in what was provided for policy and procedures, the licensee did not have the policy and procedure. On February 18, 2022, at 9:49 a.m. RN-C confirmed she had not addressed or developed any policy and procedures for treatment or therapy management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
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	01940		

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01940	Continued From page 122 individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy 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 and failed to ensure a treatment management plan was current 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	01940		

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01940	Continued From page 123 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's individualized treatment to therapy management plan lacked inclusion of all services provided, documentation of client specific instructions, procedures for notifying the RN and was current with changes. R1's Service Plan Agreement dated November 5, 2021, included the following services: putting on and removal of compression stockings, assistance with getting continuous positive airway pressure (CPAP) machine set up and on at bedtime, assistance with putting on and removal of lymphedema (swelling in arm or leg caused by lymphatic system blockage) compression device twice daily and blood sugar checks. On February 16, 2022, at 8:17 a.m. unlicensed personnel (ULP)-I was observed to check R1's blood sugar. On February 16, 2022, at 10:02 a.m. registered nurse (RN)-C was observed to check R1's INR (international normalized ratio/a test that measures the time for the blood to clot). R1's Treatment or Therapy Management Plan was dated November 4, 2021. The plan indicated additional client specific requirements relating to documentation of treatment/therapy received;" however, there was no documented information. The plan failed to indicate the licensee was providing the services of INR checks by the RN and lacked documented specific resident instructions relating to the treatments or therapy	01940		

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01940	Continued From page 124 administration and procedures for notifying the RN when a problem arises with the treatments or therapy services. UPDATE PLAN The licensee failed to update R1's individualized treatment or therapy management plan with changes. On February 16, 2022, at 9:15 a.m. R1 stated she was able to put on and remove compression stocking, CPAP and lymphedema compression wrap device without assistance. On February 16, 2022, at approximately 9:13 a.m. ULP-I stated R1 was able to put on and remove compression stockings and lymphedema compression wraps "by herself" and staff "assist with CPAP as needed." ULP-I stated R1 had "been doing" this for a "couple months now." R1's Treatment or Therapy Management Plan indicated "this treatment/therapy plan will be kept current and updated when there are any changes;" however, the plan was not updated with changes as noted above. R2 R2 lacked an individualized treatment or therapy management plan for the services of oxygen assistance. R2's Service Plan Agreement was dated September 30, 2021, signed by R1's responsible party November 6, 2021, lacked oxygen assistance. On February 16, 2022, at approximately 8:49 a.m. ULP-I stated in addition to medication administration, R2 required assistance with	01940		

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01940	Continued From page 125 "oxygen" use. On February 16, 2022, at 9:49 a.m. R2 laid in bed and was using oxygen. The oxygen concentrator was set to deliver oxygen between 2.5 and 3 liters per minute. R2's physician orders effective on February 12, 2022, read O2 (oxygen) at 2 to 3 liters per minute continuous to keep sats (oxygen saturation blood level) greater than 88%. R2's record lacked an individualized treatment and therapy management plan to include the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel ; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On February 16, 2022, at 1:34 p.m. RN-C confirmed R1's treatment to therapy management plan lacked the above content and R2's record lacked an individualized treatment or therapy management plan to include oxygen. The licensee's Administration of Medication,	01940		

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01940	Continued From page 126 Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated the RN may delegate to ULP the task of providing assistance with treatment or therapy if the RN has developed written, specific instruction for each resident and communicated with the ULP about the individual needs of the resident. 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: (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	01950		

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01950	Continued From page 127 by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for two of two residents (R1, R2) and ensured two of two unlicensed personnel (ULP-H, ULP-I) were instructed in the proper methods and had demonstrated the ability to competently follow the procedures, 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 R1's Service Plan Agreement dated November 5, 2021, included the following services: putting on and removal of compression stockings, assistance with getting continuous positive airway pressure (CPAP) machine set up and on at bedtime, assistance with putting on and removal of lymphedema (swelling in arm or leg caused by lymphatic system blockage) compression device twice daily, and blood sugar checks. On February 16, 2022, at 8:17 a.m. ULP-I was observed to check R1's blood sugar. On February 16, 2022, at approximately 9:13	01950		

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01950	Continued From page 128 a.m. ULP-I stated R1 was able to put on and remove compression stockings and lymphedema compression wraps "by herself" and staff "assist with CPAP as needed." ULP-I stated [R1] had "been doing" this for a "couple months now." On February 16, 2022, at 9:15 a.m. R1 also stated she was able to put on and remove compression stocking, CPAP and lymphedema compression wrap device without any assistance. R1's Physician Order Sheet dated December 7, 2021, included orders for compression stockings on in the a.m. and of at bedtime, lymphedema compression device twice a day for up to 60 minutes at a time, blood sugar check twice a day; and dated November 4, 2021, auto adjusting CPAP at bedtime. R1's Medication Sheet dated February 2022, indicated for blood sugar check "nurse to report to physician in A.M. if after hours, If over 450, then call physician at time of result. If blood sugar less than 70, report to nurse for further instruction." R1's record lacked in writing, specific instructions for the treatment or therapy services of putting on and removal of compression stockings, assistance with getting CPAP machine set up and on at bedtime and assistance with putting on and removal of lymphedema (swelling in arm or leg caused by lymphatic system blockage) compression device twice daily. R2 R2's Service Plan Agreement dated September 30, 2021, and signed by R1's responsible party on November 6, 2021, lacked oxygen services.	01950		

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01950	Continued From page 129 On February 16, 2022, at approximately 8:49 a.m. ULP-I stated in addition to medication administration, R2 required assistance with "oxygen" use. On February 16, 2022, at 9:49 a.m. R2 laid in bed and had oxygen in place. The oxygen concentrator was set to deliver oxygen between 2.5 and 3 liters per minute. R2's physician orders effective February 12, 2022, read O2 (oxygen) at 2 to 3 LPM (liters per minute) continuous to keep sats (oxygen saturation blood level) greater than 88% (percent). R2's Medication Sheet dated February 2022, indicated for oxygen "ensure that resident has O2 on via nasal cannula at 2 LPM. Goal is to maintain O2 > (greater than) 91%. R2's record lacked in writing, specific instructions for the treatment or therapy services of oxygen. ULP TRAINING AND DEMONSTRATED COMPETENCY ULP-H had a hire date of December 16, 2021. ULP-H's record lacked training and skills demonstration for the delegated task of CPAP. ULP-I had a hire date of January 27, 2015. ULP-I's Medication Competency Training for Nursing Assistant Registered dated January 30, 2015, indicated training for the following topics, but lacked documented skills demonstration (evidence of a written procedure and indication of pass or fail for competency evaluations): -blood sugar check	01950		

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01950	Continued From page 130 In addition, ULP-I's record lacked training and skills demonstration for the delegated tasks of: -oxygen -CPAP -compression stockings On February 16, 2022, at 1:34 p.m. RN-C confirmed R1 and R2's record lacked written, specific instructions for the above treatment or therapy services. On February 18, 2022, at approximately 9:38 a.m. RN-C confirmed ULP-H and ULP-I's records lacked evidence for the above topics for training and demonstration of skills competency for the above treatments or therapy delegated tasks. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated the RN may delegate to ULP the task of providing assistance with treatment or therapy if the RN has developed written, specific instruction for each resident and communicated communicated with the ULP about the individual needs of the resident. The licensee's Assisted Living Orientation ULP Staff policy dated August 1, 2021, indicated the ULP would receive training with written or oral test and skills demonstration for administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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01960	Continued From page 131	01960		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure administration of treatment was discontinued as prescribed for one of two residents (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: R2's Service Plan Agreement dated September 30, 2021, and was signed by R1's responsible party on November 6, 2021, indicated R2 received services which included personal care assistance of putting on and removal of	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30490	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

(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
01960	Continued From page 132 compression stockings. R2's Medication Sheet dated February 2022, identified "Ted Stockings" (compression socks) assist resident with putting on TEDS every A.M. and taking TEDS off at bedtime. Staff were documenting "ON" and "OFF" for assisting with TED stockings. On February 16, 2022, at approximately 8:49 a.m. unlicensed personnel (ULP)-I stated in addition to medication administration, R2 required "assistance with dressing," was "in bed at all times now" and required "repositioning every two hours," assistance with "oxygen" use, assistance with "toileting using a bedpan," and R2 "no longer wore" compression stockings. R2's physician orders effective February 11, 2022, discontinue compression socks daily. R2's record lacked documentation of discontinuation of compression stockings as prescribed. On February 16, 2022, at 1:34 p.m. registered nurse (RN)-C confirmed R2's record lacked documented discontinuation of compression stockings as prescribed. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated August 1, 2021, indicated the RN would document actions to implement a new prescription when it was received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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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 observation, 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's start of care date was October 20, 2021, and had diagnoses including dementia. R1 received assistance from licensee staff with administration of oral medications, blood sugar check and insulin administration. On February 15, 2022, at 3:07 p.m. executive	02260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30490	A. BUILDING: _____ B. WING _____	02/18/2022

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02260	Continued From page 134 director (ED)-B stated he was "not aware of the requirement." The licensee's Assisted Living Dementia Training policy dated August 1, 2021, indicated "A description of the training program, categories of employees trained, the frequency of training, and basic topics covered" would be "provided to consumers in writing or electronic form to residents and families or other persons who request it. A hard copy will be available upon request." 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 health care and medical, or nursing standards for one of one resident (R2) with bedrails, with record reviewed. This resulted in an immediate correction order on February 17, 2022, at 8:56 a.m. This practice resulted in a level two violation (a	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30490	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

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02310	Continued From page 135	02310		

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 February 15, 2022, at approximately 9:50 a.m. during entrance conference, registered nurse (RN)-C stated a resident who was on hospice had bedrails on their bed. RN-C stated, "No I have not," regarding completing an assessment for use of bedrails.

R2's diagnoses included congestive heart failure.

R2's Service Plan Agreement dated November 6, 2021, noted services included personal care assistance with activities of daily living.

On February 16, 2022, at 8:58 a.m. surveyor observed unlicensed personnel (ULP)-I administer medications to R2. R2's bed had upper bedrails in the upright position on both sides of the bed.

On February 16, 2022, at 9:49 a.m. surveyor observed RN-C measure R2's bedrails, which were found to be within the FDA recommended dimensional measurements. Measurements for nine (9) spaces within the bedrails measured between 2.1 inches to 3.9 inches. There was no space noted between the mattress and the side rail on each side of the bed or from the headboard to the bedrails. The bedrails were noted to be secure. RN-C confirmed there was

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02310	Continued From page 136	02310		

no assessment including measurements, or documented education of the risk and benefits for the use of the bedrails.

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), should be less than four and three quarters' inches.

The Food and Drug Administration (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."

The licensee's policy, Assessing the Safety of Side Rails dated December 17, 2015, indicated the RN would evaluate whether the side rail appears to be safe for the resident. The RN would educate the resident, the resident representative and/or family members about the risk related to the side rails, and if the side rails do not appear to meet FDA standards, the RN would recommend the side rail be removed and would recommend alternative options to reduce the risk of a fall out of bed. The RN would document these conversations and recommendations. The policy further indicated, the education the RN would provide regarding the side rail safety and risks would include potential

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02310	Continued From page 137 death due to falls, entrapment, and asphyxiation. The policy included "information from FDA regarding side rails". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On February 17, 2022, at 1:22 p.m. immediacy was removed per correspondence with evaluation supervisor. At 2:20 p.m., RN-C and exective director (ED)-B were informed in person by surveyor of the immediacy being removed. Noncompliance remains at a scope and level of D. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *02/15/22*
Time: 13:11:49
Report: 1028221027

Food and Beverage Establishment Inspection Report

Location:
Mill Stream Commons
210 West Eighth Street
Northfield, MN55057
Rice County, 66

Establishment Info:
ID #: 0019218
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Millstream Commons, LLC

Phone #: 5076500141
ID #: 22938

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

The sodium hypochlorite concentration in the dish machine was measured at 0ppm. The container of sodium hypochlorite sanitizer attached to the dish machine must be replaced. Ensure that the dish machine is being tested at least once weekly.

Comply By: 02/15/22

Surface and Equipment Sanitizers

Chlorine: = 0ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: Yes

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: Ham
Violation Issued: No

Type: Full
Date: *02/15/22*
Time: 13:11:49
Report: 1028221027
Mill Stream Commons

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Butter
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: 0 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

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

This Inspection was conducted in conjunction with HRD.

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221027 of 02/15/22.

Certified Food Protection Manager: Sara Thomas

Certification Number: FM76701 Expires: 01/27/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Sara Thomas
CFPM - (D)

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