DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

July 8, 2022

Administrator
Sunrise Village Of Milaca
115 9th Street Northwest #120
Milaca, MN 56353

RE: Initial License Number 404423
Health Facility Identification Number (HFID) 30406
Project Number SL30406015

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 December 17, 2021. The follow-up evaluation found the facility to be in substantial compliance. **Based on these findings, the conditions on the license were removed effective July 4, 2022.**

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,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE EXTENSION AND SURVEY RESULTS

Electronically Delivered

May 5, 2022

Administrator
Sunrise Village of Milaca
115 9th Street Northwest #120
Milaca, MN 56353

RE: Conditional License Number 404423
Health Facility Identification Number (HFID) 30406
Project Number(s) SL30406015

Dear Administrator:

On May 2, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on December 17, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the December 17, 2021 evaluation, and two new violations were identified.

As a result, the current Conditional License will be extended by an additional 60 days. This extension is due to expire on July 4, 2022.

All conditions noted in the Conditional Order effective on February 4, 2022, will remain in effect through the extended conditional license period.

The RN consultant will continue to provide MDH with regular reports at intervals specified by MDH. Reports will continue on a weekly basis until MDH notifies Sunrise Village of Milaca and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at casey.devries@state.mn.us. Casey DeVries can be reached at 651-201-5917 with questions about reports.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 17, 2021, found not corrected at the time of the May 2, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1 - $500.00
0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - $500.00
0730-Contents Of Resident Record-144g.43 Subd. 3
1750-Delegation Of Medication Administration-144g.71 Subd. 7 - $3,000.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 - $3,000.00

The details of the violations noted at the time of this follow-up evaluation completed on April 26, 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.

Also, at the time of this follow-up evaluation completed on May 2, 2022, we identified the following violation(s):

1890-Prescription Drugs-144g.71 Subd. 20
1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5 - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $10,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with 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 by the correction order date. 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 a complaint investigation, and as otherwise needed.

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 have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries, at 651-201-5917.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

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
	30406	A. BUILDING: _____ B. WING _____	R 05/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

(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: SL30406015 On April 25, 2022, through May 2, 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 December 17, 2021. At the time of the survey, there were thirty (30) residents receiving services under the Assisted Living license.	{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 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 SUBDIVISION 1-3.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew	{0 250}		

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{0 250}	Continued From page 1 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 commissioner; (13) violates any local, city, or township ordinance	{0 250}		

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{0 250}	Continued From page 2 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 interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. 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 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 April 25, 2022, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-A and housing manager (HM)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication	{0 250}		

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{0 250}	Continued From page 3 and treatment management services. 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, 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. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the	{0 250}		

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{0 250}	Continued From page 4 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 a license. I understand that information submitted to the commissioner in this 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 or 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, and Minnesota Rules, chapter 4659 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	{0 250}		

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{0 250}	Continued From page 5	{0 250}		

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 and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable.

Page five was electronically signed by owner/agent/licensed assisted living director (LALD)-C on May 25, 2021.

The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022.

The licensee failed to ensure the following policies and procedures were developed and/or implemented:
- orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;
- reminders for medications, treatments, or exercises, if provided;
- medication and treatment management; and
- delegation of tasks by registered nurses or licensed health professionals.

On April 27, 2022, at 9:00 a.m., CNS-A confirmed the licensee provided medication administration and management, treatment management, delegated nursing services and unlicensed personnel training but failed to implement corresponding policies and procedures, as required.

As a result of this survey, the following orders were reissued and/or issued, 0730, 1750, 1760,

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{0 250}	Continued From page 6 1890, 1960, indicating 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.	{0 250}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect the licensee's thirty (30) current residents receiving Assisted Living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{0 480}		

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{0 480}	Continued From page 7 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: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Report" dated, May 2, 2022. TIME PERIOD FOR CORRECTION: Refer to "Comply By" date noted in report.	{0 480}		
{0 730} SS=E	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;	{0 730}		

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{0 730}	Continued From page 8 (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 licensee's staff documented provided resident services according to the resident's service plans for two of three residents (R1, R6) 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	{0 730}		

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{0 730}	Continued From page 9 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: R1 R1's diagnoses included congestive heart failure (CHF). R1's service plan dated August 1, 2021, indicated R1 received services including medication administration, blood glucose (sugar) monitoring, ambulation assistance, dressing, grooming, housekeeping, laundry, bathing assistance and prosthetic device assistance. R1's service recap summary for April 2022 included the following scheduled services: blood glucose, anti-coagulation therapy, medication administration, ambulation assistance, dressing and grooming, recording vitals (blood pressure, oxygen saturation, pulse, temperature). R1's record lacked documentation verifying R1 received the following services from April 1 through 20, 2022: - 11 of 20 ambulation assistance (each day staff documented no walker); - 5 of 6 scheduled services for bathing; - 1 of 24 scheduled services for toileting; - 5 of 24 scheduled services for blood glucose check (staff documented resident had already eaten or resident was not found); - 1 of 24 scheduled services for grooming; - 1 of 24 scheduled services for dressing; - 1 of 24 scheduled services for prosthetic device; - 2 of 24 scheduled services for symptom screening; and	{0 730}		

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{0 730}	Continued From page 10 - 2 of 4 full housekeeping and bed linen services. On April 25, 2022, at approximately 1:56 p.m., clinical nurse supervisor (CNS)-A and housing manager (HM)-B stated they believed R1's scheduled services were provided, but not documented. Additionally, CNS-A stated, "We are getting much better than we were." R6 R6's diagnoses included coronary artery disease (CAD), diabetes and stroke. R6's service plan dated February 2, 2022, indicated R6 received services including medication administration, bathing, dressing, grooming/hygiene, vital sign monitoring, behavior monitoring, glucose checks, nebulizer supervision by an RN, housekeeping and laundry. R6's Service Recap Summary for March 2022 included the following schedule services: dressing, personal hygiene, symptom screening, temperature, pulse and oxygen monitoring, glucose checks, personal laundry, housekeeping, bathing and behavior monitoring. R6's record lacked documentation verifying R6 received the following services for March 1 through March 31, 2022: - 24 of 120 scheduled services for glucose checks - "declined: out of test strips" - 3 of 30 scheduled services for oxygen saturation - "no time" - 2 of 30 scheduled services for pulse - "no time" - 2 of 30 scheduled services for temperature - "no time" - 1 of 30 scheduled services for symptom screen - "not on my shift" - 1 of 5 scheduled services for Supervision:	{0 730}		

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SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

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{0 730}	Continued From page 11 Record blood glucose -"BS has not been checked due to no test strips because of insurance denial". R6's Service Recap Summary for April 2022 included the following scheduled services: dressing, personal hygiene, symptom screening, temperature, pulse and oxygen monitoring, glucose checks, personal laundry, housekeeping, bathing and behavior monitoring. R6's record lacked documentation verifying R6 received the following services for April 1 through 25, 2022: - 10 of 40 scheduled services for glucose checks - "no test strips" - 1 of 2 weekly housekeeping; - 1 of 24 lite housekeeping; and - 1 of 24 meal reminders. On April 25, 2022, at approximately 1:56 p.m., clinical nurse supervisor (CNS)-A stated, "there was a period in March when we were fighting with the insurance company to provide the testing strips." Additionally, CNS-A stated the facility had purchased a house glucometer and strips the end of March that could be used if needed. No further information was provided.	{0 730}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code:	{0 780}		

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{0 780}	Continued From page 12 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required.	{0 780}		
{0 800} SS=I	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}		

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{0 810}	Continued From page 13	{0 810}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		

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{01750} SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN) trained unlicensed personnel (ULP) in the proper methods to perform the task or procedure of carbohydrate counting for the administration of insulin for a resident and ensured ULP were able to demonstrate the ability to competently follow the procedure for three of three employees (ULP-K, ULP-L, ULP-M) 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 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:	{01750}		

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{01750}	Continued From page 15	{01750}		

(Carbohydrate counting or "carb" counting is a meal planning tool used in diabetes management to help optimize blood sugar control. It can be used with or without the use of insulin therapy. Carbohydrate counting involves determining whether a food item has carbohydrate followed by the subsequent determination of how much carbohydrate the food item has in it).

R6's Med Admin Summary dated April 2022 indicated the following diabetic medication regiment:
- Novolog 100 units/milliliter (mL) (fast-acting insulin, begins to work about 15 minutes after injection) scheduled and administered three times daily
- Novolog 100 units/mL per sliding scale (varied dose of insulin) four times daily (reference below for dosing) based on the results of a blood glucose (sugar) test scheduled to be taken four times daily
-Tresiba 100 units/mL (long-acting insulin) daily at bedtime (HS)
-Trulicity 0.75mg/0.5mL (non-insulin prescription medication to help lower blood sugars) once weekly on Wednesdays
- Metformin daily (oral medication used to decrease glucose production)

R6's April 2022 medication administration record (MAR) instructed the following:
- carb/meal related Novolog insulin 100 units/mL dose to be administered via subcutaneous (SQ) injection 10 units with regular meals (3-4 carb choices) or 15 units with large meals (5-6 carb choices)

ULP-K
ULP-K started employment with the licensee on October 26, 2021, to provide direct care services

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{01750}	Continued From page 16 to residents. On April 25, 2022, at approximately 11:50 a.m., the surveyor observed ULP-K check R6's glucose level with a result of 80. ULP-K stated she would notify the nurse of the glucose results after completion of the task. ULP-K then proceeded to administer 10 units of R6's 12:00 p.m. Novolog insulin. The surveyor asked ULP-K how she knew how much insulin to administer based on the carb parameters. ULP-K stated R6 would tell her how much he planned to eat from the menu, but that the amount to administer could get confusing to staff based on what would be considered a regular or large meal. ULP-K stated R6 did not count carbs and confirmed the RN had not trained nor instructed staff to count carbs for R6. R6's Med Recap for a Single Med dated March 1, 2022, through March 31, 2022, indicated ULP-K had completed the task of insulin administration based on variable carb counting parameters or declined the task (did not complete) for R6 on the following dates and times: - 7:00 a.m., 9, 11, 23, 25, 28, 30 - 12:00 p.m., 4, 9, 11, 12, 13, 18, 21, 26, 27, 28, 30 ULP-K's employee record lacked evidence the RN trained and confirmed ULP-K's competency for the administration of insulin based on carb counting parameters. ULP-L ULP-L started employment with the licensee on August 26, 2021, to provide direct care services to residents. R6's Med Recap for a Single Med dated March 1, 2022, through March 31, 2022, indicated ULP-L	{01750}		

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{01750}	Continued From page 17 had completed the task of insulin administration based on variable carb counting parameters or declined the task for R6 on the following dates and times: - 7:00 a.m., 3, 5, 6, 7, 17, 19, 20, 22, 24, 29, 31 - 12:00 p.m., 3, 5, 6, 7, 17, 19, 20, 22, 24, 29, 31 - 5:00 p.m., 1, 19, 20 ULP-L's employee record lacked evidence the RN trained and confirmed ULP-L's competency for the administration of insulin based on carb counting parameters. ULP-M ULP-M started employment with the licensee on March 28, 2022, to provide direct care services to residents. R6's April 2022 Med Recap for a Single Med dated April 1, 2022, through April 27, 2022, indicated ULP-M had completed the task of insulin administration based on variable carb counting parameters or declined the task for R6 on the following dates and times: - 12:00 p.m., 16 - 5:00 p.m., 16, 21 ULP-M's employee record lacked evidence the RN trained and confirmed ULP-M's competency for the administration of insulin based on carb counting parameters. On April 27, 2022, at 9:00 a.m., clinical nurse supervisor (CNS)-A confirmed ULP-K, ULP-L, ULP-M and all other ULP's tasked with R6's medication administration lacked insulin carb counting training. On April 27, 2022, at 11:17 a.m., ULP-K stated she was unsure what to administer at times as	{01750}		

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{01750}	Continued From page 18 the MAR was "confusing" with directions to administer 10 units Novolog with a regular meal (3-4 carb choices) and 15 units of Novolog with a large meal (5-6 carb choices). ULP-K stated, "how do you know what is a regular meal or a large meal" and confirmed she had not been taught carb counting for insulin administration and instead she had "typically" just chosen to administer 10 units of Novolog when scheduled. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated prior to a nurse delegating tasks to unlicensed personnel, the RN must make certain the ULP is trained in the proper method to perform the task or procedure for each resident. The licensee's 7.15 Medication and Treatment - Administration and Delegation policy dated August 1, 2021, indicated when administration of medications or treatment/therapies are delegated or assigned to ULP, the RN would ensure the ULP were instructed in the proper methods with respect to each resident and that the ULP had demonstrated to the RN the ability to competently follow the procedures. No further information was provided.	{01750}		
{01760} SS=I	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	{01760}		

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{01760}	Continued From page 19	{01760}		

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 unlicensed personnel (ULP) administered medications as ordered for one of one resident (R6) with record 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 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:

R6's diagnoses included coronary artery disease (CAD), diabetes and stroke.

On April 25, 2022, at approximately 11:50 a.m., the surveyor observed ULP-K check R6's glucose level with a result of 80. ULP-K stated she would notify the nurse of the glucose results after completion of the task. ULP-K then proceeded to administer 10 units of R6's 12:00 p.m., Novolog insulin (fast acting insulin, begins to work about 15 minutes after injection). The surveyor asked ULP-K how she knew how much insulin to

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{01760}	Continued From page 20	{01760}		

administer based on the carb parameters noted in R6's medication administration record (Carbohydrate counting or "carb" counting is a meal planning tool used in diabetes management to help optimize blood sugar control. It can be used with or without the use of insulin therapy. Carbohydrate counting involves determining whether a food item has carbohydrate followed by the subsequent determination of how much carbohydrate the food item has in it). ULP-K stated R6 would tell her how much he planned to eat from the menu, but that the amount to administer could get confusing to staff based on what would be considered a regular or large meal. ULP-K stated R6 did not count carbs and confirmed the registered nurse (RN) had not trained nor instructed staff to count carbs for R6.

R6's Med Admin Summary dated March 2022 indicated the following scheduled medications:
- amlodipine 5 milligrams (mg) take 2 tablets by mouth once daily for stable angina pectoris (chest pain)
- aspirin chewable 81 mg chew one tablet by mouth once daily for coronary artery disease (CAD)
- Clopidogrel 75 mg take one tablet by mouth daily for CAD
- isosorbide mono SR 120 mg take 2 tabs (240 mg) by mouth once daily before a meal for CAD and angina
- Lexapro 5 mg take 2 tablets (10 mg) by mouth once daily for depressive disorder
- magnesium chloride 64 mg take one tablet by mouth daily for chronic kidney disease
- metformin (oral medication used to decrease glucose (sugar) production) 500 mg take one tablet by mouth once daily for diabetes
- metoprolol succinate 50 mg sustained-release take one tablet by mouth daily for hypertension

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{01760}	Continued From page 21 - Novolog insulin inject 10 units with regular meals (3-4 carbohydrate choices) and 15 units with large meals (5-6 carbohydrate choices) for diabetes - ranolazine 500 mg controlled-release take one tablet by mouth twice daily for CAD -Trulicity (non-insulin prescription medication to help lower blood sugars) 0.75 mg/0.5 milliliter (mL) inject 0.75 mg subcutaneously (SQ) once weekly on Wednesday for diabetes - famotidine 40 mg take half tablet (20 mg) by mouth at bedtime (HS) for gastroesophageal reflux disease -Tresiba insulin (long-acting insulin) 100 unit/3 mL inject 50 units SQ every 24 hours at HS for diabetes R6's March 2022 Medication Administration Record (MAR) indicated ULPs did not administer R6's magnesium chloride or metformin doses as scheduled on the following dates and times: - 7:00 a.m.,1, 2, 3, 4, 6, 7, 9, 10 - ULP's listed the reasons for not administering as ordered as: "don't have," "not found," and "med out of stock." R6's March 2022 MAR indicated ULPs did not administer R6's Novolog as scheduled on the following dates and times: - 7:00 a.m., 24, 28, 29, 30 - ULPs documented no test strips and/or no needles as the reasons for not administering - 12:00 p.m., 22, 23 - ULPs documented "waiting on test strips" - R6 refused insulin on the following dates at 12:00 p.m., 21, 22, 25, 26, 28, 29 - ULPs documented R6 stated it was due to inability to test glucose level - 5:00 p.m., 21, 22, 28, 29 - ULPs documented "no test strips," and "resident refusing due to not having any test strips and does not want to over	{01760}		

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{01760}	Continued From page 22 due [sic] it and his BG gets to [sic] low." R6's Med Admin Summary dated April 2022 indicated the following diabetic medication regiment: - Novolog 100 units/mL scheduled and administered three times daily - Novolog 100 units/mL per sliding scale four times daily based on the results of a glucose test scheduled to be taken four times daily - Tresiba 100 units/mL daily at bedtime (HS) - Trulicity 0.75mg/0.5mL once weekly on Wednesdays - Metformin daily R6's April 2022 MAR instructed the following: - carb/meal related Novolog insulin dose be administered via SQ injection 10 units with regular meals (3-4 carb choices) or 15 units with large meals (5-6 carb choices). R6's April 2022 MAR showed ULP did not administer carb/meal related doses as scheduled for R6's Novolog on the following dates and times: - 7:00 a.m., 6, 8, 9, 10, 13, 15, 18, 20, 23, 24, 25 - ULPs documented, "refused," "refused because his blood sugar was too low," or no documentation written - 12:00 p.m., 1, 2, 3, 4, 5, 6, 8, 10, 14, 15, 16, 22, 23 - ULPs documented "resident refused", "no test strips," couldn't check glucose," "took BS after his meal," "not given as BS at 122" - 5:00 p.m., 2, 7, 9, 13, 15, 16, 17, 22, 23, 24 - ULPs documented "did not give because I took BS after he ate," "refused," "not given blood sugar is too low" R6's nursing notes dated March 1, 2022, through April 27, 2022, lacked documentation the RN	{01760}		

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{01760}	Continued From page 23	{01760}		

updated R6's physician about insulins not administered, refusals of insulin by R6 or lack of glucose testing. On March 7, 2022, clinical nurse supervisor (CNS)-A processed a physician order confirming new carb counting parameters for scheduled Novolog insulin three times daily. A second nursing note on April 7, 2022, indicated nursing requested a discontinuation of sliding scale insulin and to change glucose testing to three times daily from four times daily.

On April 27, 2022, at approximately 9:00 a.m., CNS-A confirmed staff did not administer R6's prescribed medications as ordered. CNS-A stated there had been a period in March when R6 was unable to attain diabetic supplies, in particular, testing strips for R6's glucometer. Staff documentation showed R6 had refused administration of insulin when glucose could not be checked, due to R6's concern of insulin lowering his glucose levels too much. Additionally, CNS-A stated there were times during March and April 2022 that R6 would refuse insulin administration due to a low glucose result.

On April 27, 2022, at 11: 17 a.m., ULP-K stated she was unsure what to administer at times as the MAR was "confusing" with directions to administer 10 units Novolog with a regular meal (3-4 carb choices) and 15 units of Novolog with a large meal (5-6 carb choices). ULP-K stated, "how do you know what is a regular meal or a large meal" and confirmed she had not been taught carb counting for insulin administration and instead she had "typically" just chosen to administer 10 units of Novolog when scheduled. The surveyor asked ULP-K if she would know when to hold the insulin and not administer insulin based on a low glucose result. ULP-K stated "no, there are no instructions when to hold the insulin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30406	A. BUILDING: _____ B. WING _____	R 05/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01760}	Continued From page 24 and we wouldn't hold it unless a nurse directly told us to." The surveyor was unable to determine what was administered or not administered for R6's sliding scale insulin due to inconsistent documentation and lack of correlating glucose results. Between March 1, 2022, and April 25, 2022, ULP's documented insulin administered as a total number of units and had combined the carb/meal related dose with the sliding scale dose. On other dates between March 1, 2022, and April 25, 2022, ULP's documented the carb/meal related dose separately from the sliding scale or documented a reason one type of insulin was administered or not administered and did not document on the other type. There was a lack of consistency throughout documentation of insulin administration for both carb/meal related and sliding scale. On April 27, 2022, at approximately 9:00 a.m., CNS-A stated she and a new RN were just reviewing the insulin directions provided to ULP's and the directions did seem confusing. CNS-A stated ULP's had been taught to enter a glucose result into one area and enter the number of units given into its designated area of the electronic system. The licensee's 7.36 Insulin policy dated February 28, 2022, indicated insulin medications must be administered according to the prescriber's orders. No further information was provided.	{01760}		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890		

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01890	Continued From page 25 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, licensee failed to date time-sensitive medications with an opened-on date for one of one resident (R6), and the licensee failed to ensure medication containers had the original prescription label for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 25, 2022, at approximately 11:50 a.m., the surveyor observed unlicensed personnel (ULP)-K administer R6's 12:00 p.m., insulin medication. TIME SENSITIVE MEDICATIONS R6's opened Novolog insulin pen 100 unit/ milliliter (ml) lacked a date the insulin pen had been opened and when the pen would expire. R6's opened Tresiba 100 unit/mL insulin pen	01890		

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01890	Continued From page 26 lacked the date the pen had been opened and when the pen would expire. ORIGINAL PRESCRIPTION LABELS R6's opened Novolog insulin pen 100 unit/ milliliter (ml) lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. The manufacturer's instructions for Novolog insulin pens dated January 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for the Tresiba Flextouch dated July 2018, directed to discard the pen 56 days after it had been opened, even if it still had insulin left in it. On April 25, 2022, at approximately 3:20 p.m., clinical nurse supervisor (CNS)-A confirmed all medications should have original labels and the above time sensitive medications should have been dated after opening with an open and expiration date. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
01960 SS=I	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident	01960		

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01960	Continued From page 27 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 treatments or therapies were administered as prescribed for one of one resident (R6) with blood glucose (sugar) monitoring managed by the provider. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R6's diagnoses included coronary artery disease (CAD), diabetes and stroke. R6's service plan dated February 2, 2022, indicated R6 received medication administration, dressing, grooming, bathing assistance, housekeeping, laundry, behavioral monitoring, nebulizer supervision by registered nurse, monitoring of specialized diet and glucose checks.	01960		

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01960	Continued From page 28 R6's physician orders undated, indicated R6 received glucose checks four times daily at 7:00 a.m., 12:00 p.m., 5:00 p.m., and 9:00 p.m. On April 25, 2022, at approximately 11:50 a.m., the surveyor observed unlicensed personnel (ULP)-K check R6's glucose level with a result of 80. ULP-K stated she would notify the nurse of the glucose results after completion of the task, as parameters in Rtask (electronic documentation system used by licensee) indicated to notify nurse if results were less than 90 or greater than 400. R6's Service Recap Summary dated March 2022 indicated R6's treatment record lacked documentation of completed treatments for glucose checks on the following dates and times: - 7:00 a.m., 24, 28, 29, 30 - ULPs documented "no test strips found", "out of test strips", "no test strips", "BS has not been checked due to no test strips because of insurance denial." - 12:00 p.m., 22, 28, 29, 30 - ULPs documented "waiting on test strips", "no test strips", "no test strips to check glucose." - 5:00 p.m., 21, 22, 23, 25, 28, 29 - ULPs documented "resident is out of test strips, test strips ordered and awaiting delivery", "waiting on test strips", "waiting for test strip delivery", "no test strips." - 9:00 p.m, 21, 22, 25, 28, 29 - ULPs documented "resident is out of test strips, test strips ordered and awaiting delivery", "out of test strips", "waiting on test strips to be delivered from pharmacy." R6's March 2022 MAR indicated ULPs did not administer R6's Novolog (fast-acting insulin) as scheduled 20 times due to the inability to test R6's blood glucose level on the following dates and times:	01960		

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01960	Continued From page 29 - 7:00 a.m., 23, 24, 28, 29, 30 - ULPs documented "unable to get BG resident did not want to chance it being to low", "no test strips found", "unable to get a BG due to no test strips", "can't check glucose no test strips", "unable to get a BG due to no test strips and also no needles." - 12:00 p.m., 21, 22, 23, 25, 26, 28, 29, 30 - ULPs documented "resident refused his insulin", "waiting on test strips", "resident refusing due to not having any test strips and does not want to over due it and his BG gets to low", "no strips to check glucose." - 5:00 p.m., 21, 22, 28, 29 - ULPs documented "resident declined dinner this evening", "waiting on test strips", "unable to check glucose, waiting on test strips", "no strips." - 9:00 p.m., 21, 22, 28, 29 - ULPs documented "not able to give", "BS not taken unable to give-confirmed with [CNS-A]", "no test strips." R6's Service Recap Summary dated March 21, 2022, under the 5:00 p.m. scheduled Novolog dose contained nurse comment, "Unable to check blood glucose due to resident being out of test strips. Test strips ordered and awaiting delivery. Unable to determine proper dose without blood glucose. No s/s (sign/symptom) of hypo/hyperglycemia (high or low blood sugar). Resident declined dinner meal. Will continue with current POC (plan of care) and intervene PRN (as needed)". However, under the March 22, 2022, 7:00 a.m. scheduled dose, ULP documented a blood glucose level for R6 of 128, despite the prior documentation of no test strips were available. R6's Service Recap Summary dated April 2022 indicated R6's treatment record lacked documentation of completed treatments for glucose checks on the following dates and times:	01960		

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01960	Continued From page 30 - 7:00 a.m., 3, 4 - ULPs documented "no test strips" - 12:00 p.m., 2, 3, 4, 6 - ULPs documented "no test strips", "did not want to check it right now due to an anxiety attack and he [R6] feels that the blood glucose numbers will send him over the edge." - 5:00 p.m., 2, 3 - ULPs documented "no test strips" - 9:00 p.m., 2, 3 - ULPs documented "no test strips" R6's April 2022 MAR indicated ULPs did not administer R6's Novolog eight (8) times due to the inability to test R6's blood glucose level on the following dates and times: - 7:00 a.m., 3, 4 - ULPs documented "no test strips", "no test strips so res refused" - 12:00 p.m., 2, 3, 4, 6 - ULPs documented "no test strips", "resident refused due to not knowing his BG", "refused" - 5:00 p.m., 2, 3 - ULPs documented "no test strips", "couldn't check glucose" R6's nursing notes dated March 1, 2022, through April 27, 2022, lacked documentation the RN updated R6's physician about the lack of glucose testing. On April 4, 2022, CNS-A wrote that a house glucometer with strips had been purchased for glucose testing and was available for staff to use for R6. On April 27, 2022, at approximately 9:00 a.m., clinical nurse supervisor (CNS)-A confirmed services for glucose checks could not be done and stated there had been a period in March when R6 was unable to attain diabetic supplies, in particular, testing strips for R6's glucometer. R6's individual medication management plan dated March 1, 2022, indicated the nurse would monitor	01960		

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01960	Continued From page 31 medication supplies and reordering for the resident. Staff documentation showed R6 had refused administration of insulin and/or staff had declined administration (did not administer) of insulin when glucose could not be checked. CNS-A stated staff had been taught to enter a glucose result into a designated vital sign task for glucose results and enter the number of units of insulin administered into the electronic medication administration record (EMAR). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

February 4, 2022

Administrator
Sunrise Village of Milaca
115 9th Street Northwest #120
Milaca, MN 56353

RE: Conditional License Number 404423
Health Facility Identification Number (HFID) 30406
Project Number(s) SL30406015

Dear Administrator:

The Minnesota Department of Health (MDH) completed an initial evaluation on December 17, 2021, for the purpose of assessing compliance with state licensing statutes and to determine issuance of an initial license to the above mentioned provider. Based on the initial evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90 day conditional license due to expire on **May 5, 2022**.

Conditional License Issued:
MDH will issue Sunrise Village of Milaca a conditional assisted living facility license for 90 calendar days from the date of this notice. 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 follow-up evaluation, MDH will determine if Sunrise Village of Milaca is in compliance.

The following conditions apply on the conditional assisted living facility 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:** Sunrise Village of Milaca will not admit any new residents under its conditional assisted living facility license until the MDH removes the “no new admissions” condition. Sunrise Village of Milaca must provide the Department:

i. A list of the names and birthdates of any individuals Sunrise Village of Milaca 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: Sunrise Village of Milaca will contract with an RN to provide consultation concerning all resident(s) to whom Sunrise Village of Milaca provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Sunrise Village of Milaca. 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 Sunrise Village of Milaca and MDH must review the RN's credentials and approve the selection. Sunrise Village of Milaca is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Sunrise Village of Milaca in an effort to help Sunrise Village of Milaca align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. Sunrise Village of Milaca 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 Sunrise Village of Milaca and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at casey.devries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (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 Sunrise Village of Milaca to correct the violations cited during the evaluation as well as to determine the overall practice of Sunrise Village of Milaca 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: Sunrise Village of Milaca 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 Sunrise Village of Milaca 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 Sunrise Village of Milaca is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Sunrise Village of Milaca's assisted living facility license, and Sunrise

Village of Milaca will correct violations identified during the evaluation to come into full compliance. If MDH determines Sunrise Village of Milaca is not in substantial compliance, MDH may take additional enforcement action against Sunrise Village of Milaca, 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.

Request a Hearing:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order.

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

If you have any questions, please contact Casey DeVries directly at: 651-201-5917.

Sincerely,

Maria King, RN
Interim Division Director

Minnesota Department of Health
Health Regulation Division

Electronically Delivered

January 20, 2022

Administrator
Sunrise Village Of Milaca
115 9th Street Northwest #120
Milaca, MN 56353

RE: Project Number(s) SL30406015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 17, 2021, 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 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment - $3,000.00

St - 0 - 1350 - 144g.60 Subd. 5 - Temporary Staff - $3,000.00

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

The total amount you are assessed is $9,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

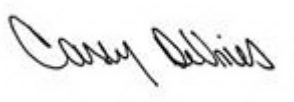
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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 Sunrise Village Of Milaca. Please contact Casey DeVries at 651-201-5917, on or before Tuesday January 25, 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,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
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Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30406	A. BUILDING: _____ B. WING _____	12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

(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, these correction orders have 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: SL#30406015 On December 13, 2021 through December 17, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were thirty (30) residents that were receiving services under the Assisted Living license. *********Update******** On December 13, 2021, an immediate order was issued for SL30406015, tag identification 0110. Immediacy was lifted on December 14, 2021. On December 14, 2021, immediate orders were issued for SL30406015, tag identification 0480 and 0800. Immediacy was lifted on December 15, 2021. On December 15, 2021, immediate orders were issued for SL30406015, tag identification 1350	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 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 SUBDIVISION 1-3.	

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0 000	Continued From page 1 and 1750. On December 20, 2021, the licensee provided information in an attempt to correct immediate orders 1350 and 1750 issued on December 17, 2021. Based on interview, record review and supervisor review, the immediacy of the licensing orders remains.	0 000		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This had the potential to affect all of the licensee's thirty (30) residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). This resulted in an immediate correction order. The findings include:	0 110		

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0 110	Continued From page 2 On December 13, 2021, at 1:20 p.m. the Minnesota Board of Executives for Long-Term Services and Support website (BELTSS) was reviewed for verification of owner (O)-C's assisted living director licensure. O-C was not listed as having a current LALD license. On December 13, 2021, at 1:40 p.m., O-C confirmed her licensure application for assisted living director was still pending and was delayed as the issuing agency was waiting on further documents. The licensee lacked a licensed assisted living director to manage and supervise assisted living services for the thirty current residents who received assisted living services. On December 13, 2021, at 2:04 p.m., housing manager (HM)- B provided a copy of the licensee's policy 4.01 Assisted Living Director dated August 1, 2021, which indicated a licensed or permitted assisted living director would maintain a current and active license or permit with Board of Executives for Long Term Services and Supports (BELTSS) and the license or permit would be hung in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE December 14, 2021, immediacy removed as confirmed by document review/email conversation between licensee and evaluation supervisor on December 14, 2021.	0 110		

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0 250	Continued From page 3	0 250		
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a 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;	0 250		

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0 250	Continued From page 4 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the 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 ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all thirty (30) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five	0 250		

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0 250	Continued From page 5 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 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 f 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	0 250		

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0 250	Continued From page 6	0 250		

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 (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 the owner on May 25, 2021.

The licensee had an assisted living license, effective August 1, 2021.

The licensee failed to ensure the following policies and procedures were in place, kept current and implemented:
- orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;
- orientation to and implementation of the assisted living bill of rights;
- 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;
- medication and treatment management;
- delegation of tasks by registered nurses or licensed health professionals; and
- supervision of unlicensed personnel performing delegated tasks.

Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention

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0 250	Continued From page 7 (CDC) including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test and training for three of four employees (unlicensed personnel (ULP)-D, ULP-G and ULP-H) with records reviewed. Refer to licensing order Statute 144G.60. Subd. 3. The licensee failed to ensure staff providing nursing services under a purported license had current credentials from the health licensing board while providing those services. Additionally, the licensee failed to ensure staff providing assisted living services used the correct authentication with name and title of the person making the entry for one of four employees (ULP-E) with records reviewed. Refer to licensing order at Statute 144G.60, Subd. 5. The licensee failed to ensure a contracted employee; one of four employees (ULP-H) received the same required training as facility staff. Refer to licensing order at Statute 144G.62, Subd. 2. The licensee failed to ensure a registered nurse (RN) conducted training and competency evaluations for two of four employees (ULP-D and ULP-H) who performed delegated tasks. Refer to licensing order at Statute 144G.62, Subd. 4. The licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for three of four employees (ULP-E, ULP-G and ULP-H) with records reviewed. Refer to licensing order at Statute 144G.63,	0 250		

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0 250	Continued From page 8 Subd. 1. The licensee failed to provide staff orientation to assisted living licensing requirements and regulations for three of four employees (ULP-D, ULP-G, and ULP-H) with records reviewed. This has the potential to affect all thirty (30) residents. Refer to licensing order at Statute 144G.64.(a) (1-2). The licensee failed to ensure three of four employees (ULP-D, ULP-G and ULP-H) received the required amount of dementia care training in the required time frame with records reviewed. Refer to licensing order at Statute 144G. 71, Subd. 5. The licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for three of three residents (R1, R2 and R3) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 6. The licensee failed to ensure two of four employees (ULP-G and ULP-H) had been trained and competency tested prior to being delegated medication administration. Refer to licensing order at Statute 144G.71, Subd. 7. The licensee failed to ensure prior to delegating nursing tasks, the unlicensed personnel were trained in the proper methods to perform the task or procedure for each resident and were able to demonstrate the ability to competently follow the procedure for two of two employees (ULP-G and ULP-H) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 8. The licensee failed to ensure medications were administered as ordered for two of three residents (R1and R2) and licensee	0 250		

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0 250	Continued From page 9 failed to ensure medications were administered according to manufacturer's instructions for one of three residents (R1) observed with insulin administration via a prefilled insulin pen, with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 22. The licensee failed to provide a disposition of medications with the required content for one of one discharged resident (R5) with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to ensure it developed an individual treatment management plan to include all required content for three of three residents (R1, R2 and R3) who received an ordered treatment. Refer to licensing order at Statute 144G.72, Subd. 4. The licensee failed to ensure unlicensed personnel were trained and demonstrated competency in treatments to a registered nurse (RN) for three of four employees (ULP-D, ULP-G and ULP-H) with records reviewed. Refer to licensing order at Statute 144G.91. Subd. 4. The licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for medication dosage box set-up. This had the potential to affect all thirty (30) residents. Thirty-four (34) 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.01 to 144G.95. No further information was provided.	0 250		

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0 250	Continued From page 10 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 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	0 470		

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0 470	Continued From page 11 plan was developed to determine staffing levels to meet the needs of all residents and the 24-hour staffing schedule was posted as required. Additionally, the licensee failed to ensure resident call pendants were functioning properly and were answered within a reasonable timeframe. This had the potential to affect all thirty (30) 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 lacked a written staffing plan, considering staff experience, training, and competency to: -provide an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week; -adequately address each resident's needs and acuity levels based on services plans, assessments, and reviews; and -consider the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises. STAFFING SCHEDULE The licensee lacked a daily staffing schedule	0 470		

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0 470	Continued From page 12	0 470		

developed by the clinical nurse supervisor to:
- identify the direct-care staff member's resident assignments or work location; and
- be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building.

On December 13, 2021, at 11:13 a.m., the surveyor did not observe a posted staff schedule to include required information in the main entry area of the facility or hallways.

On December 14, 2021, at approximately 11:05 a.m., clinical nurse supervisor (CNS)-A provided the surveryor a copy of a weekly schedule, which contained position titles and shifts covered. CNS-A stated the document had been emailed to her by owner (O)-C upon CNS-A's request. CNS-A confirmed the licensee had not developed a staffing plan or staffing schedule containing all required information to be posted in the main areas.

CALL PENDANTS

On December 13, 2021, at approximately 9:00 a.m., during the entrance interview, housing manager (HM)-B and CNS-A stated the licensee used a call pendant pager system that alerted staff, on a pager worn by staff, when a resident pushed a button requesting staff assistance.

On December 14, 2021, at 10:43 a.m., R2 stated "sometimes" it takes staff a long period of time to respond to the call pendant when activated.

On December 15, 2021, at 1:50 p.m., HM-B provided a call pendant report dated December 1, 2021, through December 15, 2021, and stated,

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SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

(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
0 470	Continued From page 13 "This looks really bad. This is because they (call pendants) don't all work properly, but the staff are aware of which ones are not working right". The call pendant report indicated during that timeframe, residents had placed calls for assistance 748 times with an average wait time of 34.3 minutes over all shifts (day, evening, night) and seventy-eight (78) of those requests had a recorded wait time of 99.59 minutes. On December 17, 2021, at approximately 1:22 p.m., O-C stated the licensee's call pendant system had been purchased second hand from an independent distributor that had since gone out of business. O-C confirmed she was aware the call pendant system was not operating correctly and, "It's been a challenge for some time". Licensee's policy 4.06 Staffing and Scheduling dated August 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan and a daily staffing schedule that would identify all required areas as noted above. Licensee's policy 2.01 24-Hour Emergency Response dated August 1, 2021, indicated the emergency response system would be activated by a resident pressing the emergency button. The alert would then notify staff via phone and be answered immediately. Additionally, the policy indicated the emergency system would be tested regularly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		

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0 480	Continued From page 14	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect the licensee's thirty (30) current residents receiving Assisted Living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 480		

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0 480	Continued From page 15 The findings include: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Report" dated, December 14, 2021. TIME PERIOD FOR CORRECTION: Refer to "Comply By" date noted in report. December 15, 2021, immediacy removed as confirmed by document review/email conversation between licensee and environment health personnel and evaluation supervisor on December 15, 2021.	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract;	0 485		

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0 485	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all thirty (30) residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 13, 2021, at approximately 10:00 a.m., during entrance conference, clinical nurse supervisor (CNS)-A and housing manager (HM)-B stated the licensee provided three meals daily and snacks twice daily. On December 13, 2021, during a tour of floors 1, 2 and 3, the surveyor observed whiteboards hung on the hallway walls with the word "Meals" written on the top. No menu items were written on the boards on floors 1, 2 or 3, and there were no menus posted in the kitchens and/or common areas. During an interview on December 15, 2021, at 1:17 p.m., HM-B stated the licensee would normally have menus posted, however, the activity director, who was responsible for doing so had been out of the building since the end of	0 485		

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0 485	Continued From page 17 October. Additionally, HM-B stated COVID and construction within the facility had created challenges. Licensee's Food Service policy dated August 1, 2021, indicated menus would be prepared at least one (1) week in advance and be made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and	0 490		

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0 490	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that created opportunities for residents to actively participate in the community at large. This had the potential to affect all thirty (30) residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a daily program of activities as required. On December 13, 14 and 15, 2021, throughout the day, afternoon and early evening hours, the surveyor did not observe any activities planned or offered. Some residents remained in their rooms, while some other residents visited with staff in the hallways. On December 15, 2021, at approximately 2:20 p.m., housing manager (HM)-B confirmed the licensee had not developed an activity program	0 490		

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0 490	Continued From page 19 with the required content. HM-B stated the licensee previously had activities; however, the activity director has been out of the building since the end of October. HM-B further stated that COVID and construction within the building had created some challenges. Licensee's policy 1.34 Activity Programming dated August 1, 2021, indicated on a regular basis licensee would provide a range of activities and social recreation for its residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure that a registered nurse was available on-call 24 hours a day, seven days per week. This had the potential to affect all thirty (30) residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 495		

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0 495	Continued From page 20 a large portion or all of the residents). The findings include: On December 13, 2021, at approximately 10:00 a.m., during entrance conference, clinical nurse supervisor (CNS)-A stated that she was the only registered nurse employed by licensee at the time of survey, however, a second registered nurse had recently been hired and was scheduled to begin "within a month, or a few weeks." On December 13, 2021, at approximately 11:00 a.m. while on tour of the facility, the surveyor observed unlicensed personnel (ULP)-E in the nurse's office processing medication orders. When the surveyor inquired to CNS-A about a nursing call schedule, CNS-A stated, "Call is shared with the CMA (certified medical assistant)." CNS-A indicated she was referencing ULP-E and stated that in an emergency, ULP-E "Would call (CNS-A) if it was something she couldn't handle." On December 13, 2021, at approximately 12:13 p.m., ULP-E confirmed that she shared an on-call rotation with CNS-A. A call policy was requested, but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 495		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550		

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0 550	Continued From page 21 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 and interview, the licensee failed to post the required information related to the grievance procedure, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all thirty (30) 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of 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, or any information for reporting suspected maltreatment to the	0 550		

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0 550	Continued From page 22 Minnesota Adult Abuse Reporting Center (MAARC). On December 13, 2021, during the facility tour at approximately 10:40 a.m., the surveyor observed the common areas and noted the lack of required posting of the grievance procedure and information related to reporting suspected maltreatment to MAARC. In addition, there was no evidence of 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, or any information for reporting suspected maltreatment to MAARC. On December 13, 2021, at approximately 3:12 p.m., housing manager (HM)-B confirmed the content noted above was not posted as required. Additionally, HM-B stated, "They may have been taken down during construction." A policy was requested, but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 600 SS=D	144G.42 Subd. 4 Handling residents' finances and property (a) A facility may assist residents with household budgeting, including paying bills and purchasing household goods, but may not otherwise manage a resident's property. (b) Where funds are deposited with the facility by the resident, the licensee: (1) retains fiduciary and custodial responsibility	0 600		

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0 600	Continued From page 23 for the funds; (2) is directly accountable to the resident for the funds; and (3) must maintain records of and provide a resident with receipts for all transactions and purchases made with the resident's funds. When receipts are not available, the transaction or purchase must be documented. (c) Subject to paragraph (d), if responsibilities for day-to-day management of the resident funds are delegated to the manager, the manager must: (1) provide the licensee with a monthly accounting of the resident funds; and (2) meet all legal requirements related to holding and accounting for resident funds. (d) The facility must ensure any party responsible for holding or managing residents' personal funds is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident funds and provides proof of the bond or insurance. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to maintain records or required receipts for resident funds that were exchanged between licensee and resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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:	0 600		

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0 600	Continued From page 24 Licensee failed to maintain records or receipts of cash exchanges between R2 and the licensee. R2's service plan dated August 1, 2021, indicated service titled (R2's name) Smile Chart was provided three (3) times daily by unlicensed personnel (ULP). On December 15, 2021, at approximately 3:10 p.m., housing manager (HM)-B and clinical nurse supervisor (CNS)-A stated the smile chart service was ordered by R2's therapist and was created as a positive reinforcement program for good behavior. HM-B stated the ULP's document behaviors, and for each day R2 has no adverse behaviors, ULP's placed a star on a calendar day. HM-B stated when R2 paid HM-B rent for the month, HM-B gave R2 cash back from R2's rent for every day that had a star. On December 15, 2021, at approximately 3:25 p.m., HM-B confirmed the licensee did not maintain receipts or records documenting the exchange of funds with R2. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: twenty-one (21) days	0 600		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	0 640		

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0 640	Continued From page 25 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas to include: posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; and posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all thirty (30) 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 a posting of the 911 emergency number in common areas and near telephones provided by the assisted living.	0 640		

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0 640	Continued From page 26 On December 13, 2021, at approximately 10:35 a.m., during the facility tour, the surveyor observed no postings with the 911 emergency number in common areas or near telephones in the nurse's office. On December 13, 2021, at approximately 3:12 p.m., housing manager (HM)-B confirmed the licensee did not post the 911 emergency number in common areas and near telephones. Additionally, HM-B stated, "They may have been taken down during construction." Licensee's Emergency Preparedness Plan policy dated August 1, 2021, did not address posting of the 911 emergency number. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 650 SS=E	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	0 650		

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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
0 650	Continued From page 27 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, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain employee records with all required content for each individual contractor providing assisted living services for one of one contracted unlicensed personnel ((ULP)-H) and one of one non-contracted employee (ULP-G) 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:	0 650		

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0 650	Continued From page 28 During the entrance conference on December 13, 2021, at 9:30 a.m., clinical nurse supervisor (CNS)-A and housing manager (HM)-B stated the licensee used one supplemental staffing agency to meet staffing needs for unlicensed personnel and that the licensee currently had one contracted employee/unlicensed personnel, (ULP-H), working shifts. Additionally, ULP-H was not listed on the licensee's employee roster and the licensee had not created or maintained an employee record for ULP-H. ULP-H The licensee lacked an employee record for ULP-H and evidence that ULP-H was oriented, trained or competency tested on delegated nursing tasks and treatments. On December 15, 2021, at 11:53 a.m., HM-B provided email documents that indicated ULP-H had a contract start date of November 16, 2021. On December 15, 2021, at approximately 12:00 p.m., CNS-A provided a staff schedule for the current week and confirmed ULP-H worked on December 12 and 14, 2021 providing direct care services to the licensee's residents. Additionally, ULP-H was scheduled to work on December 16 and 17, 2021, of the current week schedule. CNS-A and HM-B confirmed the licensee did not have an employee record for ULP-H and HM-B stated, "I didn't think we needed one." On December 18, 2021, at 7:59 p.m., ULP-H stated she started working shifts for the licensee around December 3, 2021, and provided direct care services to the licensee's residents. ULP-H stated the job duties performed included medication administration, treatments and	0 650		

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0 650	Continued From page 29	0 650		

resident assistance. ULP-H stated her hours were typically weekend overnight shifts and afternoon shifts during the week. ULP-H stated she did not recall what paperwork she completed with the licensee prior to starting employment.

ULP-G
ULP-G had a hire date of October 15, 2021. ULP-G was initially hired as a kitchen worker and later transferred to provide direct care services to residents following ULP-G's request for additional work hours.

ULP-G's employee record lacked the following:
- record of orientation, infection control training and competency evaluation;
- current job description, including qualifications, responsibilities and identification of staff persons providing supervision;
- for individuals providing assisted living services, verification that required health screenings under subdivision 9 had taken place and the dates of those screenings.

On December 15, 2021, at approximately 12:00 p.m., CNS-A provided a current staff schedule and confirmed ULP-G worked on December 12, 13, and 14, 2021 and provided direct care services to the licensee's residents. Additionally, ULP-G was scheduled to work December 18, 2021, of the current schedule.

On December 15, 2021, at approximately 12:25 p.m., CNS-A and HM-B verified no contracted staff providing services for the licensee had employee records. CNS-A and HM-B stated they did not know licensee was required to provide training and maintain employee records for supplemental contracted staff. HM-B referenced an email provided to licensee by the outside

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0 650	Continued From page 30 agency prior to supplying contracted staff, which instructed the licensee was responsible for providing all required training as if contracted staff were a new hire for the licensee. HM-B stated, "I missed that part of the email." Regarding ULP-G, CNS-A stated the licensee urgently needed staff to assist residents, and ULP-G had requested more hours. CNS-A and HM-B confirmed ULP-G was scheduled and allowed to work shifts prior to meeting the assisted living stautory requirements. Licensee's 4.07 Temporary and Contracted Staff policy dated August 1, 2021, indicated contracted staff would only be used if they met the same requirements that are required of hired employees and would be treated as if they were staff of the facility. Licensee's 4.05 Employment Records policy dated August 1, 2021, indicated the licensee would keep an employee record for all paid employees. Employee records would be kept up-to-date and contain all training records, in-service education, signed job description and verification of completed orientation and competency testing as required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660		

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0 660	Continued From page 31 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 observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to complete a facility risk assessment and ensure employees completed TB training for three of four employees (unlicensed personnel (ULP)-E, ULP-G and ULP-H) with employee records reviewed. The licensee also failed to ensure screenings for health history, symptoms, and active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of four employees (ULP-E and ULP-H) with employee records reviewed. This had the potential to affect all thirty (30) 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 660		

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0 660	Continued From page 32	0 660		

has affected or has the potential to affect a large portion or all of the residents).

The findings include:

TB RISK ASSESSMENT

During the entrance conference on December 13, 2021, at approximately 9:45 a.m., surveyor requested the facility TB risk assessment to review. Clinical nurse supervisor (CNS)-A provided a blank facility TB risk assessment for review and stated it had not been completed.

The licensee's employee records lacked evidence of a completed health history and symptom screening, including completion of a two-step TST or other evidence of TB screening, such as a blood test. Additionally, licensee failed to provide TB training to staff as required.

TB TRAINING

ULP-E, ULP-G and ULP-H's employee records lacked evidence of required TB training completion at the time of hire.

ULP-E had a hire date of August 21, 2021, to provide direct care services to licensee's residents.

On December 14, 2021, at approximately 11:30 a.m., ULP-E was observed clarifying medication orders with pharmacy for R2.

ULP-G had a hire date of October 15, 2021, to provide kitchen services and direct care services to residents.

On December 14, 2021, at approximately 9:20

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0 660	Continued From page 33 a.m., CNS-A confirmed ULP-G provided direct care services to licensee's residents. ULP-H had a contracted hire date of November 16, 2021, to provide direct care services to licensee's residents. On December 17, 2021, at approximately 7:59 p.m., ULP-H confirmed she provided direct care services to licensee's residents. On December 14, 2021, at 9:30 a.m., CNS-A and housing manager (HM)-B confirmed ULP-E, ULP-G and ULP-H did not receive TB training upon hire as required. TB HISTORY AND SYMPTOM SCREEN ULP-E had a hire date of August 21, 2021, to provide direct care to licensee's residents. ULP-E's employee record lacked the following as required: - documentation of a completed health history and symptom screening; and - completion of a two-step TST or other evidence of TB screening such as a blood test. ULP-H had a contracted hire date of November 16, 2021, to provide direct care to licensee's residents. ULP-H's employee record lacked the following as required: - documentation of a completed health history and symptom screening; and - completion of a two-step TST or other evidence of TB screening such as a blood test. On December 14, 2021, at approximately 9:30 a.m., CNS-A confirmed ULP-E and ULP-H did not	0 660		

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0 660	Continued From page 34 complete the required TB history and symptom screening, a two-step TST, or a blood test as required. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated all direct care staff must have documentation of a baseline health screening prior to providing care to residents, to include assessment for current symptoms of active TB and testing for the presence of infection with a two-step TST, single blood test, or chest x-ray. The same policy indicated staff would be educated regarding TB at the time of hire. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients and a baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680	Continued From page 35	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not 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 have a written emergency preparedness plan with all the required content and post an emergency preparedness plan prominently. This had the potential to affect all thirty (30) residents receiving services under the assisted living license.	0 680		

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0 680	Continued From page 36 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 13, 2021, at approximately 9:00 a.m., a surveyor requested to review the licensee's emergency preparedness plan. The licensee's plan, included a Hazard Vulnerability Assessment dated August 1, 2021, which identified 12 events (such as fire, tornado, winter storm) and scored each event based on probability, risk and preparedness. Licensee's emergency preparedness plan had a generic outline of what should be included in an emergency preparedness plan with several checklist forms that could be used in emergencies, such as missing resident, water main break, gas line break, water/electrical outage, fire and natural disasters (tornado watch/warning, blizzard, and flooding). Licensee's emergency preparedness plan included contact information for some external emergency and service contacts and natural disaster policies and procedures (not all customized to the facility). The emergency employee roster and emergency family/physician contact tabs were blank. The licensee's emergency preparedness plan lacked the following required content: - a comprehensive program to include infectious	0 680		

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0 680	Continued From page 37 diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - an evacuation plan customized for the facility; - a fire safety plan customized for the facility; - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; and - the licensee's role in providing care and treatment at alternative sites. - a communication plan that addressed: - arrangements with other facilities; - names and contact information for staff, resident physicians, and other facilities; - contact information for federal, state, tribal, local EP staff, and ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing resident information and medical documentation; - a means to provide information regarding the facility's needs, and its ability to provide assistance, including occupancy information; and -a method of sharing information from the licensee's emergency plan with residents and their families. - EP training and testing program;	0 680		

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0 680	Continued From page 38 - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On December 13, 2021, at approximately 10:30 a.m., during a facility tour with housing manager (HM)-B, the surveyor observed no signage or information posted in the main entrance or elsewhere in the facility regarding the licensee's emergency plan. On December 15, 2021, at approximately 9:20 a.m., HM-B confirmed staff were not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which includes the emergency preparedness guidelines). HM-B verified the licensee had not developed and implemented the facility's emergency preparedness plan/program as required. The licensee's 9.02 Disaster Planning and Emergency Preparedness policy dated August 1, 2021, noted the facility would have a general emergency preparedness plan in place in alignment with the requirement to also comply with CMS Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=C	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	0 730		

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0 730	Continued From page 39 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 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	0 730		

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0 730	Continued From page 40 (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 observation, interview and record review, the licensee failed to ensure licensee's staff documented provided resident services according to the residents' service plans for three of three residents (R1, R2 and R3) 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, R2 and R3's records lacked documentation of services provided by the licensee's staff. R1 R1's diagnoses included congestive heart disease, Type II diabetes mellitus and neurological complications. R1's service plan dated August 1, 2021, indicated R1 received services, including medication administration, blood glucose (sugar) monitoring, prosthetic device assistance, dressing, grooming, housekeeping, laundry, and assistance with bathing. On December 14, 2021, at approximately 11:39	0 730		

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0 730	Continued From page 41 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R1's morning medication. R1's service recap summary for November 2021 included the following scheduled services: blood glucose, medication administration, recording vital signs, dressing and grooming. R1's record lacked documentation verifying R1 received the following services from November 10 through 30, 2021: - 22 of 95 scheduled services for medication administration; - 19 of 38 scheduled services for housekeeping; - 19 of 60 scheduled services for blood glucose check; - 19 of 20 scheduled services for blood pressure check; - 2 of 19 scheduled services for grooming; - 2 of 19 scheduled services for dressing; - 2 of 19 scheduled services for prosthetic device; - 2 of 19 scheduled services for symptom screening; and - 3 of 4 full housekeeping and bed linen services. On December 15, 2021, at approximately 1:10 p.m., clinical nurse supervisor (CNS)-A and housing manager (HM)-A stated they believed R1's scheduled services were provided, but not documented. R2 R2's diagnoses included schizo-affective disorder, congestive heart failure, Type II diabetes and chronic obstructive pulmonary disease. R2's service plan dated August 1, 2021, indicated R2 received services including medication administration, housekeeping, laundry, and	0 730		

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0 730	Continued From page 42 assistance with bathing, dressing, grooming, and toileting. On December 14, 2021, at approximately 10:40 a.m., the surveyor observed ULP-I provide R2 medication administration assistance. R2's Service Recap Summary for December 2021 included the following scheduled services: dressing, grooming, behaviors, personal laundry, and vital signs monitoring with temperature, pulse and oxygen saturation. R2's record lacked documentation verifying R2 received the following services from December 1 through 15, 2021: - 4 out of 88 scheduled services for oxygen; - 2 out of 20 scheduled services for dressing/undressing; - 2 out of 20 scheduled services for grooming; - 2 out of 20 scheduled services for behaviors/anxiety; - 2 out of 20 scheduled services for behaviors/irritability; - 3 out of 10 schedule services for weight monitoring; - 3 out of 4 scheduled services for personal laundry; and - 6 of 30 scheduled services for temperature, pulse and oxygen saturation monitoring. On December 15, 2021, at approximately 1:10 p.m., CNS-A and HM-A stated they believed R2's scheduled services were provided, but not documented. R3 R3's diagnoses included diabetes mellitus Type II, major depressive disorder, psychotic features,	0 730		

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0 730	Continued From page 43 anxiety and chronic kidney disease stage 3. R3's service plan dated March 24, 2021, indicated R3 received services, which included medication administration, bathing, dressing, grooming/hygiene, bowel management, vital sign monitoring, housekeeping and laundry. R3's Service Recap Summary for November 2021 included the following scheduled services: dressing, personal hygiene, bowel and bladder management, symptom screening, temperature, pulse and oxygen monitoring, glucose checks, personal laundry, housekeeping, bathing and behavior monitoring. R3's record lacked documentation verifying R3 received the following services for November 1 through 30, 2021: - 2 of 30 scheduled services for dressing pm; - 2 of 30 scheduled services for grooming; - 2 of 30 scheduled services for ace wraps; - 5 of 30 scheduled services for HHA special tasks; - 8 of 60 scheduled services for behavior monitoring and management; - 50 of 164 scheduled services for vital sign monitoring to include pulse, temperature, respiration, oxygen saturation, and blood pressure; and - 4 of 35 scheduled services for housekeeping and personal laundry. On December 15, 2021, at approximately 1:10 p.m., CNS-A and HM-A stated they believed R3's scheduled services were provided, but not documented. A policy was requested, but not provided.	0 730		

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0 730	Continued From page 44 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff and	0 780		

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0 780	Continued From page 45 visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 14, 2021, between 11:15 a.m. and 12:30 p.m., survey staff toured the facility with maintenance staff(MS)-F. During the tour, the following observations were made: When individual dwelling unit smoke alarms were tested by MS-F, none of the other smoke alarms within the dwelling unit were activated. During the tour interview, MS-F confirmed that smoke alarms were not interconnected within individual dwelling units. At approximately 1:40 p.m., survey staff observed from the hallway the smoke alarm battery compartment was open and empty in room 109. On December 14, 2021, between 3:45 p.m. and 4:00 p.m., housing manager (HM)-B confirmed a battery needed to be installed in the smoke alarm for room 109. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 800	Continued From page 46	0 800		
0 800 SS=I	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 in a continuous state of good repair and operation with regard to the health, safety and well-being of the residents. This had the potential to directly affect all residents, staff and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 14, 2021 between 11:15 a.m. and 12:30 p.m., survey staff toured the facility with maintenance staff(MS)-F. During facility tour, survey staff observed: 1. The door separating the construction area from the hallway where resident rooms 101, 102 and 103 were located had been removed. No	0 800		

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construction or dust barrier was installed to protect residents from construction dust.
2. Three doors were held open by magnetic holds within the construction area. No construction or dust barrier had been installed to protect residents from construction dust.
3. Plywood was being cut with a circular saw while these doors were held open. Dust was observed on the floor of the construction area and in the resident area hallways.
4. Residents would be able to enter the construction area as access was unrestricted. Power tools were observed within construction area and not stored securely to prevent access by residents.

On December 14, 2021, at approximately 10:30 a.m., housing manager (HM)-B explained that new flooring was being installed in the construction area for the dining room and lobby. She stated that the project started on November 29, 2021; it was anticipated to be complete the first week of January. Survey staff asked if residents were living in rooms 101, 102 and 103, as the hallway for these rooms provided direct access to the construction area. HM-B stated a resident lived in room 103 and was able to access other areas of the building or go outside to smoke by going through the construction area.

On December 14, 2021, at approximately 12:30 p.m., MS-F confirmed that the doors within the construction area were open.

Current guidelines from the 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 recommends implementing infection-control measures relevant

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0 800	Continued From page 48 to construction, renovation, maintenance, demolition, and repair. The CDC recommends construction barriers be installed to prevent dust from construction areas from entering resident-care areas. The CDC also recommends relocating patients whose rooms are adjacent to work zones, depending on their immune status, the scope of the project, and the potential for the generation of dust or water aerosols. These recommendations and additional CDC recommendations can be found in the CDC MMWR's "Guidelines for Environmental Infection Control in Health-Care Facilities" Report issued on June 6th, 2003. An online version of the report can be found at the following address: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE December 15, 2021, immediacy removed as confirmed by document review/email conversation between licensee and engineering personnel and evaluation supervisor on December 15, 2021. UPDATED WITH ADDITIONAL INFORMATION BELOW: On December 14, 2021, between 11:15 a.m. and 12:30 p.m., survey staff toured the facility with maintenance staff(MS)-F. In addition to items 1 though 4 noted above, survey staff also observed: 5. The third-floor laundry room door was missing. The first-floor laundry room door was propped open with an attached doorstop and was not staffed. MS-F explained during the tour interview	0 800		

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that the third-floor laundry room door had been removed and was installed elsewhere within the building. They further explained that a replacement door had been ordered for the laundry room, and they were still waiting for it to arrive. MS-F confirmed that the laundry room door on the first floor should not be propped open when this room was unstaffed.
6. Numerous holes were observed in the hallway walls. Base cove was peeling away from walls in one of the first-floor hallways. MS-F confirmed during the tour interview that the walls and base cove required repair.
7. The exterior door often used by residents when exiting the building to use the patio lacked a tight seal along the bottom. MS-F confirmed during the tour interview that the door was in poor condition due to frequent use.
8. In the first-floor shower room, the bathtub was loose, the area underneath the bathtub was not enclosed leaving electrical wires visible, and tile was missing around the bathtub edges. MS-F explained during the tour interview that the bathtub was not used by residents and that the installation was never completed. MS-F further explained that the wiring underneath the basin had been disconnected.
9. The sidewalk and steps were covered in snow outside the fire exit door near room 109. MS-F confirmed during the tour interview that this fire exit needed to be maintained free of snow and ice.
10. Several emergency lights did not work when tested. MS-F stated during the tour interview that these exit lights required maintenance.
11. Several fire doors did not auto-latch when tested. MS-F stated during the tour interview that the fire doors required maintenance.
12. Several resident room doors were covered from top to bottom in holiday decorations and

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0 800	Continued From page 50 room numbers were obstructed. MS-F confirmed during the tour interview that the door numbers were not visible. 13. The first-floor utility room electrical panel was obstructed. MS-F confirmed during the tour interview that the electrical panel was blocked. 14. The reduced pressure zone valve tag was dated 2005 in the first-floor utility room. MS-F stated that he did not know when the PRZ valve was last inspected. No further information was provided. 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 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.	0 810		

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0 810	Continued From page 51 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the required training, drills, and plans for fire safety and evacuation. 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: On December 14, 2021, between 11:15 a.m. and 12:30 p.m., survey staff toured the facility with maintenance staff (MS)-F. During the tour, survey staff observed that no evacuation maps were posted within the facility. On December 14, 2021, at approximately 12:30 p.m., housing manager (HM)-B provided records	0 810		

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0 810	Continued From page 52 for review. 1. The licensee's 7.05 fire policy dated 08/14/2017 failed to include: a. the location and number of resident rooms; b. identification of unique or unusual resident needs for movement or evacuation. 2. The licensee failed to provide documentation of annual fire and evacuation training for residents. 3. The licensee failed to provide the required staff training frequency for fire safety and evacuation. The Disaster Plan Procedure Binder (no date) stated that fire safety and evacuation training was provided upon employee hire and then annually. 4. The Fire Drill Sign-In Form provided was dated January 22, 2021. No additional fire drill sign-in forms were provided for review. On December 14, 2021, at approximately 1:30 p.m., HM-B confirmed that the fire policy required revision and that staff training requirements were not met. HM-B stated residents were trained every 6 months, but no training records were available. HM-B explained the current evacuation drill frequency schedule was every 6 months. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01310 SS=F	144G.60 Subd. 3 Licensed health professionals and nurses (a) Licensed health professionals and nurses providing services as employees of a licensed	01310		

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01310	Continued From page 53 facility must possess a current Minnesota license or registration to practice. (b) Licensed health professionals and registered nurses must be competent in assessing resident needs, planning appropriate services to meet resident needs, implementing services, and supervising staff if assigned. (c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff providing nursing services under a purported license had current credentials from the health licensing board while providing those services. Additionally, the licensee failed to ensure staff providing assisted living services used the correct authentication with name and title of the person making the entry for one of four employees (unlicensed personnel (ULP)-E) 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-E's electronic signature did not reflect the correct title for the position worked.	01310		

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01310	Continued From page 54 On December 13, 2021, at approximately 12:15 p.m., the surveyor observed ULP-E processing physician orders in the nurse's office for R2. A New Employee Checklist dated August 18, 2021, indicated ULP-E was hired as a licensed practical nurse (LPN). A Staff Activity Trail dated November 15, 2021, through December 17, 2021, indicated ULP-E performed and signed off in licensee's Rtask documentation system as an LPN as follows: - wrote one hundred nine (109) resident notes; - updated two (2) health professionals; - updated one (1) health plan; - sent staff nineteen (19) resident care directive messages to include medication changes; - reassigned two (2) resident services; - charted ten (10) wound care; - set up twenty-three (23) medication dosage boxes; and - transcribed seventy-eight (78) medication orders into the electronic medication system (MAR) for administration by staff. On December 16, 2021, at 1:10 p.m., clinical nurse supervisor (CNS)-A confirmed ULP-E was not a LPN and was performing LPN tasks for licensee's residents. Additionally, CNS-A stated that she was unaware a certified medical assistant (CMA) could not perform the job duties of a LPN. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records would contain evidence of current professional licensure and a current signed job description that would include qualifications. The licensee's 7.09 Medication Management -	01310		

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01310	Continued From page 55 Dosage box setup policy dated August 1, 2021, indicated a licensed nurse would transcribe medication orders and setup resident dosage boxes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01310		
01330 SS=F	144G.60 Subd. 4 Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of four unlicensed personnel ((ULP)-D, ULP-E and ULP-G) completed training and competency evaluations prior to providing delegated nursing tasks to	01330		

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SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

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01330	Continued From page 56	01330		

residents, with records reviewed. This had the potential to affect all thirty (30) residents receiving assisted living services.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

ULP-D, ULP-E and ULP-G's employee records lacked evidence of completed training and demonstrated competency in all the required topics.

ULP-D was hired on October 4, 2021, to provide direct care services to licensee's residents.

On December 14, 2021, at approximately 11:39 a.m., the surveyor observed ULP-D assist R1 with insulin administration.

ULP-E was hired on August 21, 2021, to provide direct care services to licensee's residents.

On December 13, 2021, at approximately 12:13 p.m., the surveyor observed ULP-E processing medication orders.

ULP-G was hired on October 15, 2021, to assist in the kitchen and later transferred to providing direct care services to licensee's residents by the end of November, 2021.

A posted staff schedule dated December 12,

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01330	Continued From page 57 2021, through December 18, 2021, indicated ULP-G provided delegated nursing services for licensee's residents December 12, 13, 14 and 18, 2021. ULP-D and ULP-G's employee record lacked evidence of training and demonstrated competency in the following areas: -documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - maintenance of a clean and safe environment; -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; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - 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; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; - awareness of commonly used health technology equipment and assistive devices; - observing, reporting, and documenting resident status;	01330		

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01330	Continued From page 58 - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motion and positioning; and - administering medications and treatments as required. ULP-E's employee record lacked evidence of training or demonstrated competency in the following areas: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motion and positioning. On December 15, 2021, at 12:10 p.m., the housing manager (HM)-B and clinical nurse supervisor (CNS)-A confirmed ULP-D, ULP-E and ULP-G's employee record lacked evidence of completed training and competency testing in topics listed in 144G.61, subdivision 2. CNS-A stated the licensee urgently needed staff to work on the floor with residents and confirmed ULP-D, ULP-E and ULP-G were allowed to work shifts providing delegated nursing services to the licensee's residents prior to completing required	01330		

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01330	Continued From page 59 training and competency. Licensee's 5.01 Orientation of Staff and Supervisors and Content policy dated August 1, 2021, indicated all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. Licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated prior to unlicensed personnel performing delegated nursing services, the registered nurse would make certain that unlicensed personnel were trained in the proper methods to perform the tasks or procedures and demonstrate the ability to competently perform the tasks. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01330		
01350 SS=I	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure contracted staff met all requirements for personnel employed by the licensee for one of one unlicensed personnel (ULP)-H) with records reviewed.	01350		

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01350	Continued From page 60 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 13, 2021, at 9:00 a.m., housing manager (HM)-B confirmed the licensee utilized contracted unlicensed personnel (ULP) to maintain staffing for the facility. ULP-H had a contracted hire date of November 16, 2021 and began providing delegated nursing services to licensee's residents on December 3, 2021. A posted staff schedule dated December 12, 2021, through December 18, 2021, indicated ULP-H provided delegated nursing services for licensee's residents December 12, 14, 16 and 17, 2021. The licensee did not maintain an employee record for ULP-H, therefore there was no evidence of the following required content of orientation to assisted living: -overview of assisted living statutes; -review of the provider's policies and procedures; -assisted living bill of rights; -handling of resident complaints, reporting of complaints, and where to report; and -principles of person-centered planning and service delivery.	01350		

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01350	Continued From page 61 Additionally, there was no evidence to indicate ULP-H received training and was competent in the following areas: -documentation requirements for all services provided; -appropriate and safe techniques in personal hygiene and grooming to include: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids and dressing and assisting with toileting; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise and treatment reminders; -basic nutrition, meal preparation, food safety and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -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; -understanding appropriate boundaries between staff and residents and the resident's family; -awareness of commonly used health technology equipment and assistive devices; -observing, reporting, and documenting of resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning;	01350		

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01350	Continued From page 62 -administering medications or treatments as required; and -other registered nurse (RN) delegated tasks including but not limited to unplanned time away medications, fall alarms, catheter care and mechanical lifts. On December 15, 2021, at 12:07 p.m., housing manager (HM)-B confirmed ULP-H did not have an employee record or the above required orientation, training, and competencies. Clinical nurse supervisor (CNS)-A stated she believed the temporary staffing agency providing the staff also provided the required training and competency evaluations. Email correspondence from the Minnesota Department of Health (MDH), dated November 10, 2021, time stamped 2:44 p.m., addressed to HM-B, informed the licensee that licensee would need to provide necessary training and orientation to the contracted staff, as licensee would for hired employees. On December 15, 2021 at approximately 12:10 p.m., HM-B stated, "I missed that part of the email." The licensee's 4.07 Temporary and Contracted Staff policy dated August 1, 2021, indicated temporary supplemental staffing or contracted staff will only be used if they meet the same requirements required of hired employees and will be treated as if they are staff of the facility. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated all staff providing and supervising direct care services must complete an orientation of Assisted Living facility licensing requirements	01350		

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01350	Continued From page 63 and regulations before providing assisted living services to residents. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated when a registered nurse (RN) delegated tasks, prior to the delegation of services the RN must make certain the ULP was trained in the proper methods to perform the tasks or procedures and able to demonstrate the ability to competently follow the procedures and perform the tasks. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated direct care employees would complete eight hours of initial training within 80 hours of the employment start date, with the topics to include: an explanation of Alzheimer's disease and other dementias, assistance with activities of daily living, problem solving with challenging behaviors, communication skills and person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE ***UPDATE*** On December 17, 2021, at 3:18 p.m., HM-B provided a forty-five (45) page Educare training package titled Competency Testing to the Minnesota Department of Health (MDH) supervisor. Each page of the training document indicated ULP-H had completed competency testing with CNS-A and CNS-A had dated each skill completed on December 16, 2021. All forty-five (45) pages lacked ULP-H's signature. On December 17, 2021, at 7:59 p.m., the MDH	01350		

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01350	Continued From page 64 surveyor conducted an interview with ULP-H about the training that had been completed. ULP-H stated she had completed 17 educare modules prior to starting with licensee and had completed a shadowing process for two days with various ULP's employed by licensee. ULP-H stated she had spent "about a half-hour going through a checklist" with CNS-A on December 16, 2021. The surveyor asked ULP-H who had provided training for medications, treatments and cares, ULP-H responded with "the nurses". When the surveyor asked for clarification of the nurse's name, ULP-H provided the name of ULP-I. On December 20, 2021, at 11:50 a.m., the surveyor interviewed CNS-A about the training process and ULP's providing competency evaluations. CNS-A confirmed she had spent "maybe an hour of her doing teach back." The surveyor asked CNS-A for clarification of teach back and CNS-A stated she was referring to going over the checklist with ULP's. CNS-A stated she did not think it was a requirement to train and competency test ULP-H. Based on interview, record review and supervisor review, the immediacy of the licensing order remains.	01350		
01390 SS=F	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies.	01390		

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01390	Continued From page 65 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure that a registered nurse was available for consultation to staff performing delegated nursing tasks and services including therapies. This had the potential to affect all thirty (30) residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On December 13, 2021, at approximately 10:00 a.m., during entrance conference, clinical nurse supervisor (CNS)-A stated she was the only registered nurse employed by licensee at the time of survey; however, the licensee recently hired a second registered nurse who was scheduled to begin "within a month, or a few weeks." Additionally, CNS-A stated that licensee employed two CMA's (certified medical assistant). CNS-A indicated they were ULP-E and ULP-I. On December 13, 2021, at approximately 11:00 a.m., while on tour of the facility, the surveyor observed unlicensed personnel (ULP)-E in the nurse's office, processing medication orders. When the surveyor inquired to CNS-A about a nursing call schedule, CNS-A stated, "Call is shared with the CMA (certified medical	01390		

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01390	Continued From page 66 assistant)." CNS-A indicated she was referencing ULP-E in regard to the call rotation and stated that in an emergency, ULP-E "Would call (CNS-A) if it was something she couldn't handle." On December 13, 2021, at approximately 12:13 p.m., ULP-E confirmed she shared an on-call rotation with CNS-A. ULP-E's employee record indicated ULP-E was hired on August 18, 2021. ULP-E's employee record contained a signed job description titled CMA/LPN dated September 13, 2021, signed by ULP-E and CNS-A. A certified medical assistant document with ULP-E's name was present in ULP-E's personnel file. An Assisted Living Nurse Orientation Checklist, that included on-call orientation, dated September 13, 2021, indicated ULP-E completed nurse orientation and CNS-A signed off the nurse orientation document as the trainer. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01390		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to	01420		

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01420	Continued From page 67 demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for unlicensed personnel (ULP) prior to perfoming delegated nursing tasks for two of four employees (ULP-D and 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), 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-D was hired on October 4, 2021, to provide direct care services to the licensee's residents. ULP-D's employee record lacked documentation a RN trained and evaluated competency for ULP-D with catheter cares or continuous positive airway pressure (CPAP) machines.	01420		

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01420	Continued From page 68 On December 15, 2021, at approximately 10:30 a.m., record review indicated ULP-D had provided catheter cares and CPAP assistance to R2 from December 3, 2021, to December 13, 2021. ULP-H ULP-H was contract hired on November 16, 2021, through a temporary staffing agency to provide direct care services to the licensee's residents. ULP-H's employee record lacked documentation a RN trained and evaluated competency for ULP-H with catheter cares or CPAP machines. On December 15, 2021, at approximately 10:50 a.m., record review indicated ULP-H had provided catheter cares and CPAP assistance to R2 from December 3, 2021, to December 13, 2021. On December 15, 2021, at approximately 12:30 p.m., clinical nurse supervisor (CNS)-A and housing manager (HM)-B confirmed the RN did not train or evaluate competency for ULP-G or ULP-H with catheter cares or CPAP machines. The licensee's 4.05 Employee Record policy dated August 1, 2021, indicated each employee record would include all required training and in-service for unlicensed personnel and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420		

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01440	Continued From page 69	01440		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff carrying out a delegated task within 30 days of providing nursing services for three of four employees (unlicensed personnel (ULP)-E, ULP-G and 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	01440		

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01440	Continued From page 70 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-E was hired on August 21, 2021, to provide direct care services to licensee's residents. ULP-G was hired on October 15, 2021, to assist in the kitchen and later transferred to providing direct care services to licensee's residents by the end of November 2021. ULP-I was hired on November 6, 2021, to provide direct care services to licensee's residents. ULP-E, ULP-G, and ULP-I's employee records lacked documentation the RN conducted direct supervision of the ULP carrying out a delegated task within 30 days of the ULP first carrying out the delegated task for residents. Resident (R)2's Services Delivered documentation dated December 3, 2021, through December 13, 2021, indicated ULP-E, ULP-G and ULP-I provided delegated nursing services to R2 on several dates, including medication administration. On December 15, 2021, at approximately 12:35 p.m., clinical nurse supervisor (CNS)-A confirmed she had not completed supervision of staff carrying out delegated tasks for ULP-E, ULP-G or ULP-I. CNS-A stated she did not think that direct supervision by an RN was required for ULP-E or ULP-I because they were certified medical assistants.	01440		

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01440	Continued From page 71 A supervision of unlicensed personnel policy was requested, but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01440		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for three of four employees (unlicensed personnel (ULP)-D, ULP-G, and ULP-H) with records reviewed. This has the potential to affect all thirty (30) 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	01460		

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01460	Continued From page 72 of the residents). The findings include: ULP-D, ULP-G and ULP-H's employee records did not contain documentation of completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. ULP-G and ULP-H's record failed to contain the following: - an overview of this chapter; - 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; - the 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 advocay services; and - a review of the types of assisted living services the employee will be providing and the facility's	01460		

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01460	Continued From page 73 category of licensure. ULP-D was hired on October 4, 2021, to provide direct care services to licensee's residents. On December 14, 2021, at approximately 11:39 a.m., the surveyor observed ULP-D administer R1 his scheduled morning medications. ULP-D's employee records lacked documentation of orientation to meet assisted living licensure requirements and regulations. ULP-G was hired on October 15, 2021, to assist in the kitchen and later transferred to providing direct care services to the licensee's residents by the end of November 2021. R2's Completed Services report dated December 3, 2021, through December 13, 2021, indicated ULP-G provided direct care services including medication administration, to R2. ULP-G's employee records lacked documentation of orientation to meet assisted living licensure requirements and regulations. ULP-H was contract hired on November 16, 2021, through a temporary staffing agency to provide direct care services to the licensee's residents. R2's Completed Services report dated December 3, 2021, through December 13, 2021, indicated that ULP-H provided direct care services including medication administration, to R2 on multiple overnight shifts. On December 15, 2021, at approximately 12:40 p.m., clinical nurse supervisor (CNS)-A and	01460		

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01460	Continued From page 74 housing manager (HM)-B stated ULP-H did not have an employee training file, and ULP-G and ULP-H did not receive the required assisted living licensure orientation. Licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated all staff providing and supervising direct services must complete an orientation to assisted living facility requirements and regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		
01530 SS=F	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	01530		

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01530	Continued From page 75 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 four employees (unlicensed personnel (ULP)-D, ULP-G and ULP-H) received the required amount of dementia care training in the required time frame with records reviewed. This had the potential to affect all thirty (30) 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: ULP-D was hired on October 4, 2021, to provide direct care services to the licensee's residents. On December 14, 2021, at approximately 11:39 a.m., the surveyor observed ULP-D administer R1 his scheduled morning medications. ULP-D's employee records did not contain documentation ULP-D completed 8 hours of dementia training within 160 hours of ULP-D's	01530		

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01530	Continued From page 76 start date. ULP-D's record indicated ULP-D had no dementia training. ULP-G was hired on October 15, 2021, to assist in the kitchen and later transferred to provide direct care services to licensee's residents by the end of November 2021. ULP-G's employee records did not contain documentation ULP-G completed 8 hours of dementia training within 160 hours of ULP-G's start date. ULP-G's record indicated ULP-G had no dementia training. ULP-H was contract hired on November 16, 2021, through a temporary staffing agency to provide direct care services to licensee's residents. ULP-H did not have an employee training file and ULP-H's employee records did not contain documentation ULP-H completed 8 hours of dementia training within 160 hours of ULP-H's start date. ULP-H's record indicated ULP-H had no dementia training. On December 15, 2021, at approximately 12:45 p.m., housing manager (HM)-B and clinical nurse supervisor (CNS)-A verified dementia training was not completed for the unlicensed staff. Additionally, CNS-A and HM-B stated they were unaware it was a requirement to train ULP-H and that ULP-G, "Was urgently needed on the floor, and he wanted more hours." A dementia training policy was requested, but not received. No further information was provided.	01530		

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01530	Continued From page 77 TIME PERIOD FOR CORRECTION: Fourteen (14) days	01530		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (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	01730		

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01730	Continued From page 78 reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for three of three residents (R1, R2 and R3) 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: During the entrance conference on December 13, 2021, at approximately 9:00 a.m., clinical nurse supervisor (CNS)-A and housing manager (HM)-B stated the licensee provided medication management services for the licensee's residents. R1's diagnoses included congestive heart failure, Type II diabetes, chronic kidney disease and major depressive disorder.	01730		

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01730	Continued From page 79 R1's service plan dated August 1, 2021, indicated R1 received medication management services six (6) times daily. R1's electronic medication administration record (EMAR) dated November 2021 included the following medications: a mild pain reliever, a medication to stabilize heart rate, one blood thinner, one thyroid replacement, one diuretic, one steroid, one medication to treat heartburn, one antipsychotic and one vitamin. On December 14, 2021, at approximately 11:39 a.m., unlicensed personnel (ULP)-D administered R1's morning medication. R1's medication management plan lacked the following: - identification of medication management tasks that may be delegated to ULP; - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services; - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and - completion of medication reconciliation. R2's diagnoses included schizo-affective disorder, congestive heart failure, obesity and Type II diabetes with neuropathy. R2's service plan dated August 1, 2021, indicated R2 received medication management services eight (8) times daily.	01730		

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01730	Continued From page 80	01730		

R2's electronic medication administration record (EMAR) dated December, 2021, included the following medications: a narcotic pain reliever, one antibiotic, a medication to stabilize the heart rate, one diuretic, one steroid, one medication to treat heartburn, one thyroid medication, two antipsychotics, two insulins, and one multivitamin.

On December 14, 2021, at approximately 11:31 a.m., unlicensed personnel (ULP)-D administered R2's morning medication.

R2's medication management plan lacked the following:
- identification of medication management tasks that may be delegated to ULP;
- procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services;
- any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and
- completion of medication reconciliation.

R3's diagnoses included Type II diabetes mellitus, hypertension, end stage renal disease and major depressive disorder.

R3's service plan dated March 24, 2021, indicated R3 received medication management services six (6) times daily.

R3's electronic medication administration record (EMAR) dated November 2021 included the following medications: a pain reliever, one diuretic, one medication to treat nerve pain, one

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01730	Continued From page 81 medication to treat heartburn, one thyroid medication, one cholesterol lowering medication, one insulin and two vitamins. R3's medication management plan lacked the following: - identification of medication management tasks that may be delegated to ULP; - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services; - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and - completion of medication reconciliation. On December 15, 2021, at approximately 2:50 p.m., CNS-A confirmed R1, R2 and R3's individualized medication management plans did not include all the required content. CNS-A verified all resident's individualized medication management plans would lack the above noted content. A policy for individualized medication management plans was requested, but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01740 SS=E	144G.71 Subd. 6 Administration of medication	01740		

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01740	Continued From page 82 Medications may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure unlicensed personnel (ULP) were trained and competency tested prior to a registered nurse (RN) delegating medication administration to two of four employees (ULP-G and 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 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-G was hired on October 15, 2021, to assist in the kitchen and later transferred to provide direct care services for licensee's residents by the end of November 2021. ULP-G's record lacked documentation a RN trained and competency tested ULP-G prior to delegating the task of medication administration to ULP-G. A Staff Activity Trail report dated December 8,	01740		

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01740	Continued From page 83 2021, through December 15, 2021, indicated ULP-G administered 115 anti-psychotics, blood thinners, diuretics and narcotic pain medications as follows: - December 8, 2021, medications administered to eleven (11) residents; - December 11, 2021, medications administered to seven (7) residents; - December 12, 2021, medications administered to one (1) residents; - December 13, 2021, medications administered to three (3) residents; - December 14, 2021, medications administered to five (5) residents; and - December 15, 2021, medications administered to five (5) residents. ULP-H was contract hired on November 16, 2021, through a temporary staffing agency to provide direct care services to licensee's residents. ULP-H did not have an employee training record; there was no documentation a RN trained and competency tested ULP-H prior to delegating the task of medication administration to ULP-H. A Staff Activity Trail report dated November 29, 2021, through December 15, 2021, indicated ULP-H administered 352 anti-psychotics, blood thinners, diuretics and narcotic pain medications as follows: - December 4, 2021, medications administered to four (4) residents; - December 5, 2021, medications administered to two (2) residents; - December 10, 2021, medications administered to six (6) residents;	01740		

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SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

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01740	Continued From page 84 - December 11, 2021, medications administered to fourteen (14) residents; - December 12, 2021, medications administered to seventeen (17) residents; - December 13, 2021, medications administered to four (4) residents; and - December 14, 2021, medications administered to nine (9) residents. On December 15, 2021, at 12:07 p.m., housing manager (HM)-B and clinical nurse supervisor (CNS)-A confirmed the licensee did not have any employee training records for ULP-H and that ULP-G and ULP-H both lacked the required training prior to administering medications to licensee's residents. CNS-A also stated she thought the temporary staffing agency provided all the required training to ULP-H and one other previous temporary staff persons the licensee had employed. On December 15, 2021, at 12:10 p.m., HM- B and CNS-A confirmed that ULP-G was allowed to work on the floor with residents prior to training and competency due to the facility having an urgent need for staff coverage at that time. Licensee's 7.15 Medication and Treatment - Administration and Delegation policy dated August 1, 2021, indicated the registered nurse (RN) may delegate medication administration to unlicensed staff after the unlicensed personnel have demonstrated the ability to competently follow procedures and written records, signed by a RN, would be maintained regarding the ULP training and competency testing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01740		

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01740	Continued From page 85 days	01740		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating nursing tasks, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each client, and were able to demonstrate the ability to competently follow the procedure for two of two employees (ULP-G and ULP-H) 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 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).	01750		

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01750	Continued From page 86 The findings include: ULP-G started employment with the licensee on October 15, 2021, as a kitchen staff member. Licensee's Staff Activity Trail dated December 8, 2021, through December 15, 2021, indicated ULP-G had administered medications to licensee's residents as follows: - on December 8, 2021, between 3:42 p.m. and 8:34 p.m., ULP-G administered medications to ten (10) residents of the licensee. - on December 11, 2021, between 7:15 p.m. and 10:45 p.m., ULP-G administered medications to eight (8) residents of the licensee. - on December 12, 2021, at 7:34 p.m. ULP-G administered medications to one (1) resident of the licensee. - on December 13, 2021, between 11:14 p.m. and 11:47 p.m., ULP-G administered medications to two (2) residents of the licensee. - on December 14, 2021, between 11:50 p.m. and 11:57 p.m., ULP-G administered medications to two (2) residents of the licensee. - on December 15, 2021, between 12:17 a.m. and 5:39 a.m., ULP-G administered medications to five (5) residents of the licensee. ULP-G's employee record lacked evidence ULP-G had been trained and demonstrated competency for the administration of oral, topical, injectable or any other medications. Rtask medication administration records indicated ULP-G had administered anti-psychotics, blood thinners, diuretics and narcotic pain medications to the above noted residents. ULP-H started employment with licensee on November 29, 2021, following a request by the licensee to the Minnesota Department of Health	01750		

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01750	Continued From page 87 (MDH) for crisis staffing assistance. ULP-H was provided to licensee by a temporary staff agency. Licensee's Staff Activity Trail dated November 29, 2021, through December 15, 2021, indicated ULP-H had administered medications to licensee's residents as follows: - on December 4, 2021, between 10:21 p.m. and 10:51 p.m., ULP-H administered medications to four (4) residents of the licensee. - on December 10, 2021, between 3:48 p.m. and 10:18 p.m., ULP - H administered medications to nine (9) residents of the licensee. - on December 11, 2021, between 7:40 p.m. and 10:50 p.m., ULP-H administered medications to ten (10) residents of the licensee. - on December 12, 2021, between 3:25 a.m. and 11:24 p.m., the following day, ULP-H administered medications to twelve (12) residents of the licensee. - on December 13, 2021, between 12:47 a.m. and 6:16 a.m., ULP-H administered medications to six (6) residents of the licensee. - on December 14, 2021, between 6:42 a.m. and 9:47 p.m., ULP-H administered medications to eight (8) residents of the licensee. ULP-H's employee record lacked evidence ULP-H had been trained and demonstrated competency for the administration of oral, topical, injectable or any other medications. ULP-H had administered anti-psychotics, blood thinners, diuretics and narcotic pain medications to the above noted residents. On December 15, 2021, at 12:07 p.m., housing manager (HM)-B and clinical nurse supervisor (CNS)-A confirmed the licensee did not have any employee training records for ULP-H and that ULP-G and ULP-H both lacked the required	01750		

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01750	Continued From page 88	01750		

training prior to administering medications to licensee's residents. CNS-A also stated that she thought the temporary staffing agency had provided all the required training to ULP-H and one other previous temporary staff that licensee had employed.

On December 15, 2021, at 12:10 p.m., HM- B and CNS-A confirmed that ULP-G was allowed to work on the floor with residents prior to training and competency due to the facility having an urgent need for staff coverage at that time.

Licensee's policy 5.02 Competency Training Evaluations dated August 1, 2021, indicated prior to a nurse delegating tasks to unlicensed personnel, the registered nurse must make certain the unlicensed personnel is trained in the proper method to perform the task or procedure for each resident.

Licensee's policy 7.15 Medication and Treatment - Administration and Delegation dated August 1, 2021, indicated when administration of medications or treatment/therapies are delegated or assigned to unlicensed personnel, the registered nurse would ensure that the unlicensed personnel were instructed in the proper methods with respect to each resident and that the ULP had demonstrated to the registered nurse the ability to competently follow the procedures.

No further information was provided.

TIME PERIOD FOR CORRECTION: IMMEDIATE

UPDATE
On December 17, 2021, at 3:18 p.m., HM-B provided two (2), forty-five (45) page Educare

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01750	Continued From page 89 training packages titled Competency Testing to the Minnesota Department of Health (MDH) supervisor for ULP-G and ULP-H. Each page of the training document indicated ULP-G and ULP-H had completed competency testing with CNS-A and CNS-A had dated each skill completed on December 16, 2021. All forty-five (45) pages lacked ULP-G and ULP-H's signatures. On December 17, 2021, at 7:59 p.m., the MDH surveyor conducted an interview with ULP-H about the training that had been completed. ULP-H stated she had completed 17 educare modules prior to starting with licensee and had completed a shadowing process for two days with various ULP's employed by licensee. ULP-H stated she had spent "about a half-hour going through a checklist" with CNS-A on December 16, 2021. The surveyor asked ULP-H who had provided training for medications, treatments and cares, ULP-H responded with "the nurses". When they surveyor asked for clarification of the nurse's name, ULP-H provided the name of ULP-I. ULP-G did not return calls to the MDH surveyor or provide an interview. On December 20, 2021, at 11:50 a.m., the surveyor interviewed CNS-A about the training process and ULP's providing competency evaluations. CNS-A confirmed she had spent "maybe an hour of her doing teach back." The surveyor asked CNS-A for clarification of teach back and CNS-A stated she was referring to going over the checklist with ULP's. CNS-A stated she did not think it was a requirement to train and competency test ULP-H. Additionally, CNS-A stated ULP-G had requested more hours to work and licensee "urgently" needed staff to work shifts with residents.	01750		

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01750	Continued From page 90 Based on interview, record review and supervisor review, the immediacy of the licensing order remains.	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff administered medications as ordered for two of three residents (R1 and R2) with records reviewed. The licensee also failed to ensure staff administered medications according to manufacturer's instructions with insulin administration via a prefilled insulin pen, for one of three residents (R1) observed. 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	01760		

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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:

MEDICATIONS NOT ADMINISTERED AS ORDERED/MEDICATION ERROR

R1
R1's diagnoses included congestive heart failure, Type II diabetes, chronic kidney disease and major depressive disorder.

R1's medication administration summary (MAR) dated November 2021 indicated R1's physician ordered Ergocalciferol (vitamin D) 50000 units, once weekly on Fridays.

R1's November 2021 MAR showed staff did not administer R1's three of three Vitamin D doses scheduled on the following dates and times:
- 9:00 a.m., November 12, 2021 - "could not find"
- 9:00 a.m., November 19, 2021 - "does not have"
- 9:00 a.m., November 26, 2021 - "not here"

R2
R2's diagnoses included schizo-affective disorder, congestive heart failure, obesity and Type II diabetes with neuropathy.

R2's MAR dated December 2021 indicated R2's physician ordered Aripiprazole (antipsychotic used to treat schizo-affective disorder) 5 milligram (mg), one tablet daily.

R2's December 2021 MAR showed staff did not

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administer twelve of twelve Aripiprazole doses between December 1, 2021, and December 14, 2021. R2 was hospitalized December 7 and 8, 2021.

Staff indicated on the MAR Aripiprazole was out of stock twelve out of fourteen days and skipped and that the nurse was notified two out of fourteen days as follows:
- December 1, 2, 3, 4, 5, 6, 9, 10, 13, and 14, 2021 - "out"
- December 11 and 12, 2021 - "skipped, med out of stock, nurse notified"

On December 14, 2021, at approximately 2:20 p.m., clinical nurse supervisor (CNS)-A confirmed staff did not administer R1 and R2's prescribed medications as ordered. CNS-A stated sometimes the insurance and pharmacy process caused delays in residents receiving medications.

Licensee's 7.19 Medication and Supplies - Reordering policy dated August 1, 2021, indicated nursing staff would assist residents to make sure medications and supplies are ordered and available as needed.

PROCESS OF MEDICATION ADMINISTRATION

R1's diagnoses included congestive heart failure, Type II diabetes mellitus, chronic kidney disease and major depressive disorder.

R1's Service Plan dated August 1, 2021, and Individualized Medication Management Plan dated November 30, 2021, indicated R1 received medication management services, which included medication administration.

R1's Med Admin Summary dated November 2021

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included Novolog insulin, 8 units subcutaneously (SQ) to be administered twice daily before lunch and supper.

On December 14, 2021, at approximately 11:33 a.m., the surveyor observed unlicensed personnel (ULP)-D use appropriate technique to conduct a blood glucose check on R1, which resulted in a reading of 133 milligrams (mg)/deciliter (dL). ULP-D confirmed with R1 and the electronic medication record (MAR) that R1 would receive 8 units of Novolog insulin. ULP-D prepared the Novolog insulin pen (a multiple dose pen shaped injector device used for insulin administration) by placing the needle on to the end of the insulin pen and immediately dialed the pen to 8 units. R1 raised his shirt up, and ULP-D used an alcohol wipe to cleanse an area on the left side of R1's abdomen. ULP-D proceeded to inject the 8 units of Novolog insulin into R1's upper abdomen. The surveyor did not observe ULP-D prime the insulin pen prior to dialing up the prescribed Novolog insulin dose and administering 8 units of Novolog insulin to R1.

On December 14, 2021, at approximately 11:40 a.m., ULP-D confirmed she did not prime the insulin pen prior to dialing the prescribed insulin dose. ULP-D stated she should have primed the Novolog insulin pen with two units prior to dialing up the prescribed 8 units.

On December 14, 2021, at approximately 12:05 p.m., clinical nurse supervisor (CNS)-A confirmed the ULP should make sure the insulin pen was primed prior to dialing up the prescribed dose of insulin.

The manufacturer's instructions for the use of Novolog insulin pens dated January 2019

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01760	Continued From page 94 directed for the insulin pen to be primed with two units prior to dialing the prescribed dosage and, if not completed before each injection, too much or too little insulin may be administered. Licensee's 7.36 Insulin policy dated August 1, 2021, referred to mixing insulin and the syringe process. The provided policy did not address the use of an insulin pen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure residents' refrigerated medications were maintained at the manufacturer's recommended temperatures by failing to monitor and document medication refrigerator temperatures for the refrigerator located in the nurse's office. The licensee also failed to properly secure, monitor and include a daily narcotic count of 288 tablets of various narcotic medications. 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	01880		

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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:

MEDICATION STORAGE PER MANUFACTURER'S RECOMMENDATION

On December 13, 2021, at approximately 12:15 p.m., the surveyor observed the medication refrigerator located in the locked nurse's office with unlicensed personnel (ULP)-E. ULP-E confirmed the current temperature of the refrigerator was 20 degrees Fahrenheit (F) on the thermometer. ULP-E called the clinical nurse supervisor (CNS)-A to the nurse's office to review the refrigerator temperature. CNS-A confirmed the 20 degrees Fahrenheit (F) temperature and stated, "We've had issues with it for awhile, that is why we keep the insulin on the bottom area." CNS-A additionally stated the temperatures were monitored daily and recorded in licensee's Rtask electronic record. The surveyor observed the refrigerator contained the following medications:

- thirteen (13) unopened Novolog 100 units/milliliters (ml) insulin pens (a multiple dose pen shaped injector device for insulin administration) for R2;
- nine (9) unopened Novolog 100 units/milliliters (ml) insulin pens for R1;
- eight (8) unopened Basaglar 100 units/ml insulin pens for R1; and
- three (3) Trulicity 18 milligrams/3 ml pens for R2.

The manufacturer's instructions for Novolog

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insulin pens dated November 2019 indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze.

The manufacturer's instructions for Basaglar insulin pens dated December 2015 indicated unopened pens should be stored in the refrigerator at 36 to 46 degrees F.

The manufacturer's instructions for Trulicity pens dated September 2020, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze.

On December 13, 2021, at approximately 12:30 p.m., CNS-A stated a temperature log report was unavailable for review. The surveyor observed a temperature log sheet hanging on the refrigerator dated September 2021 did not contain recorded temperatures. CNS-A then removed an insulin pen from the refrigerator, held it up to the light for inspection, and stated the insulin did not appear frozen. CNS-A confirmed the above noted temperature readings were not within the acceptable range.

Licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen).

STORAGE AND SECURITY OF SCHEDULE II DRUGS

On December 13, 2021, at approximately 12:15 p.m., the surveyor observed the nurse's office with ULP-E. The surveyor observed the presence of one (1) thirty-gallon plastic garbage bag and an

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01880	Continued From page 97	01880		

eighteen-by-eighteen inch cardboard box overflowing with plastic-coated cardboard bubble packs, which contained a variety of pill form medications. On a shelf next to the entrance door was one (1) three-gallon, clear plastic tub, unsecured, which was three quarters full and contained a variety of loose, unlabeled pills. ULP-E confirmed all noted medications were pending disposition, and it was ULP-I's responsibility to perform the medication disposition task.

On December 13, 2021, at approximately 12:25 p.m., the surveyor asked CNS-A if narcotics were included in the pending medication disposition. CNS-A removed three (3) boxes containing a variety of narcotics from the unlocked cupboard and stated the narcotics were also pending disposition. The surveyor and CNS-A counted the narcotics and agreed that a total of 288 pills of schedule II drugs were present. CNS-A confirmed that staff did not count the narcotics each shift or include them in routine monitoring. CNS-A stated that she and two certified medical assistants (CMA)'s hired as licensed practical nurses (LPN)'s possessed keys to the nursing office. CNS-A was referring to ULP-E and ULP-I.

Licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated optional but suggested to protect staff and minimize diversion, schedule II drugs would be counted at the beginning and end of every shift with counts compared to schedule II medications ordered to be administered.

Licensee's 7.26 Narcotic log policy dated August 1, 2021, indicated not required but suggested best practice would be that all schedule II-controlled substances would be counted and

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	30406	A. BUILDING: _____ B. WING _____	12/17/2021

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SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

(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
01880	Continued From page 98 recorded on the narcotic count sheet at the start of the day shift and during the evening shift. The policy further indicated the registered nurse supervisor would verify the documentation in the narcotic log, including counts and records regularly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	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 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01910		

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01910	Continued From page 99	01910		

review, the licensee failed to properly dispose of various medications, overfilling a 30-gallon trash bag and a three-gallon plastic container located in the nursing office. Additionally, the licensee failed to dispose of narcotic medications that remained at the facility five (5) months after the discharge of one of one resident (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), 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:

MEDICATION DISPOSAL

On December 13, 2021, at approximately 12:15 p.m., the surveyor observed the nurse's office with unlicensed personnel (ULP)-E. The surveyor observed the presence of one (1) thirty-gallon plastic garbage bag and an eighteen-by-eighteen inch cardboard box overflowing with plastic-coated cardboard bubble packs that contained a variety of pill form medications. A review of the medication packages revealed medications dated back to April 2021 that were expired, were prescription changes, or had belonged to residents that were discharged during the previous nine (9) months. On a shelf next to the entrance door was one (1) three-gallon, clear plastic tub, unsecured, which was three quarters full and contained a variety of loose, unlabeled pills. ULP-E confirmed all noted medications were pending disposition, and it was

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01910	Continued From page 100 ULP-I's responsibility to perform the medication disposition task. On December 13, 2021, at approximately 12:25 p.m., the surveyor asked CNS-A if narcotics were included in the pending medication disposition piles. CNS-A removed three (3) boxes containing a variety of narcotics from the cupboard and stated the three (3) boxes of narcotics were also pending disposition. The surveyor and CNS-A counted the narcotics and agreed that a total of 288 pills of schedule II drugs were present. CNS-A confirmed staff did not count the narcotics each shift or include narcotics in routine monitoring. Licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated it was optional but suggested to protect staff and minimize diversion that schedule II drugs would be counted at the beginning and end of every shift, with counts compared to schedule II medications ordered to be administered. Licensee's 7.26 Narcotic log policy dated August 1, 2021, indicated, not required but suggested it was best practice that all schedule II-controlled substances be counted and recorded on the narcotic count sheet at the start of the day shift and during the evening shift. The policy further indicated the registered nurse supervisor would verify the documentation in the narcotic log including counts and records regularly. Additionally, the policy indicated discontinued controlled substances would continue to be counted with the regular narcotic inventory until destroyed. DISPOSITION RECORD	01910		

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01910	Continued From page 101 Resident (R)5 was discharged from the licensee's facility on August 24, 2021. R5's discharge record did not include a record of the inventory or destruction of R5's prescribed Lyrica 50 milligram (mg) narcotic medication. On December 13, 2021, at approximately 12:25 p.m., the surveyor observed three (3) boxes of schedule II drugs (narcotic) located in the nurse's office cupboard. CNS-A counted the narcotics and confirmed that 177 pills of Lyrica 50 milligram schedule II drugs, which belonged to R5, had not been disposed of and were not being monitored in the daily count. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated the licensee would dispose of any medications remaining upon the termination of the resident's service contract. The policy also indicated the licensee would document in the resident's record the disposition of the medication to include the medication's name, prescription number as applicable, quantity, and to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy	01940		

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01940	Continued From page 102 services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (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 individual treatment management plans with all required content for three of three residents (R1, R2 and R3) who received ordered treatments. 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	01940		

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01940	Continued From page 103	01940		

resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1
R1's diagnoses included congestive heart failure, Type II diabetes mellitus, chronic kidney disease and major depressive disorder.

R1's service plan dated August 1, 2021, indicated R1 received treatment and therapy services including glucose monitoring three (3) times daily.

R1's Individualized Treatment and Therapy Plan dated December 15, 2021, lacked inclusion of the correct designated individual to provide supervision. The plan indicated the licensed practical nurse (LPN) would provide supervision of treatments administered by unlicensed personnel (ULP).

On December 14, 2021, at approximately 11:39 a.m., the surveyor observed ULP-D obtain R1's blood sugar, which was 133 milligrams per deciliter (mg/dl). The surveyor asked ULP-D if R1's blood sugar reading was considered within the normal limits for R1. ULP-D stated she was unsure but if she had questions, she could ask the nurse.

R1's Individualized Treatment and Therapy Plan lacked the following content:
-documentation of specific resident instructions relating to the treatment or therapy administration;
-procedures for notifying a registered nurse or

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appropriate licensed health professional when a problem arises with the treatments or therapy services; and
-any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions.

R2
R2's diagnoses included schizo-affective disorder, obesity, Type II diabetes with neuropathy, incontinence and chronic diastolic heart failure.

R2's service plan dated August 1, 2021, indicated R2 received treatment and therapy services including glucose monitoring three (3) times daily, oxygen, ace wraps, skin treatments, (continuous positive airway pressure) CPAP and catheter cares.

R2's Individualized Treatment and Therapy Plan dated December 15, 2021, lacked inclusion of the correct designated individual to provide supervision. The plan indicated the LPN would provide supervision of treatments for ULPs.

On December 14, 2021, at approximately 11:55 a.m., the surveyor observed ULP-J administer R2's morning scheduled medications and check the status of R2's oxygen tank.

R2's Individualized Treatment and Therapy Plan lacked the following content:
-documentation of specific resident instructions relating to the treatment or therapy administration;
-procedures for notifying a registered nurse or

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01940	Continued From page 105 appropriate licensed health professional when a problem arises with the treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification all treatment and therapy was administered as prescribed, and monitoring to prevent possible complications or adverse reactions. R3 R3's diagnoses included Type II diabetes mellitus, hypertension and acute pancreatitis. R3's service plan dated August 24, 2021, indicated R3 received treatment and therapy services including glucose monitoring three (3) times daily. R3's Individualized Treatment and Therapy Plan dated December 15, 2021, lacked inclusion of the correct designated individual to provide supervision. The plan indicated the LPN would provide supervision of treatments to ULPs. R3's Individualized Treatment and Therapy Plan lacked the following content: -documentation of specific resident instructions relating to the treatment or therapy administration; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification all treatment and therapy was administered as prescribed, and monitoring to prevent possible complications or adverse reactions.	01940		

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01940	Continued From page 106 During the entrance conference on December 13, 2021, at approximately 9:00 a.m., housing manager (HM)-B and clinical nurse supervisor (CNS)-A confirmed the licensee provided treatment and therapy services to residents. CNS-A stated she was the only licensed nurse employed by the licensee; however, the licensee had hired two (2) certified medical assistants (CMA) that performed the job duties of an LPN. CNS-A stated she was unaware CMAs could not perform licensed nursing duties. On December 15, 2021, at approximately 2:45 p.m., CNS-A confirmed R1, R2 and R3's individualized Treatment and Therapy Plans lacked the above noted requirements. The licensee's 7.05 Treatment and Therapy Management Plan policy dated August 1, 2021, indicated for each resident receiving treatments or therapy services, the licensee would prepare and include in the resident's service plan a written statement of the treatment or therapy services to be provided and would include the specific components listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
01950 SS=E	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	01950		

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01950	Continued From page 107 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 by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) trained and verified competency with treatments and therapies for unlicensed personnel (ULP) for two of four employees (ULP-D and 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 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:	01950		

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01950	Continued From page 108 ULP-D ULP-D was hired on October 4, 2021, to provide direct care services to residents. ULP-D's employee record lacked documentation ULP-D was trained and demonstrated competency to a RN to perform blood glucose monitoring. R1's service plan dated August 1, 2021, included blood glucose (sugar) monitoring three times a day. On December 14, 2021, at approximately 11:39 a.m., they surveyor observed ULP-D perform R1's blood glucose monitoring. ULP-H R2's service plan dated August 1, 2021, indicated R2 would wear a continuous positive airway pressure (CPAP) machine at bedtime and required assistance with cleaning. ULP-H was contract hired on November 16, 2021, through a temporary staffing agency to provide direct care services to residents. ULP-H did not have an employee record or documentation to indicate ULP-H was trained and demonstrated competency to a RN to perform CPAP tasks. On December 14, 2021, at approximately 11:33 a.m., the surveyor observed a CPAP machine on a table next to R2's bed. ULP-D verified R2 wears the CPAP machine at night; evening and night staff assisted with the placement. ULP-D verified staff are scheduled to clean the machine daily and check water levels.	01950		

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01950	Continued From page 109 R2's Service Recap Summary dated December 2021 indicated ULP-H provided CPAP assistance to R2 three (3) out of ten (10) days. On December 15, 2021, at approximately 1:45 p.m., clinical nurse supervisor (CNS)-A and housing manager (HM)-B confirmed ULP-D and ULP-H had not been trained or demonstrated competency to the RN as indicated above. CNS-A stated she did not think ULP-H required training as a contract employee. The licensee's 7.05 Treatment or Therapy Management Plan policy dated August 1, 2021, indicated treatment and therapies will be delegated to the unlicensed personnel after they have demonstrated their ability to competently follow the treatment/therapy to a registered nurse. Written records, signed by the registered nurse would be maintained regarding the ULP training and competency testing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=F	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	02310		

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review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for medication dosage box set-up. This had the potential to affect all thirty (30) 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:

On December 13, 2021, at approximately 12:15 p.m., the surveyor observed ULP-E in the nurse's office performing a licensed nurse task of processing medical orders and making changes to the electronic medical records system.

On December 14, 2021, at approximately 9:30 a.m., a Staff Activity Trail dated November 15, 2021, through December 17, 2021, indicated ULP-E performed medication dosage box set-up on November 23, 2021, for twenty-two (22) residents.

On December 15, 2021, at approximately 1:50 p.m., clinical nurse supervisor (CNS)-A confirmed ULP-E had performed medication dosage box set-up and processed medication orders into the electronic medication system used by ULPs to administer medications to the licensee's thirty (30) residents. Additionally, CNS-A stated she was unaware that a certified medical assistant (CMA) is not permitted to conduct licensed nursing tasks in an assisted living.

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02310	Continued From page 111 Based on the National Guidelines for Nursing Delegation, developed by the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. The licensee's policy 7.09 Medication Management - Dosage Box Setup dated August 1, 2021, indicated a licensed nurse would setup resident dosage boxes timely and accurately. A licensed nurse would assure medication orders were transcribed into the electronic medication administration record and when the licensed nurse has completed setting up dosage boxes, the setup is documented into the electronic record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/14/21*
Time: 11:05:05
Report: 7930211210

Food and Beverage Establishment Inspection Report

Location:
Sunrise Village Of Milaca
115 9th Street Nw #120
Milaca, MN56353
Mille Lacs County, 48

Establishment Info:
ID #: 0038417
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3209827000
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

BAG OF RAW HAMBURGER WAS STORED ON AND NEXT TO BAGS OF READY TO EAT TURKEY AND ROAST BEEF IN THE UPRIGHT COOLER IN THE KITCHEN. STORE READY TO EAT FOODS ABOVE RAW ANIMAL FOODS OR SEPARATE LIKE STATED ABOVE.

Comply By: 12/14/21

7-200 Toxic Supplies and Applications

7-201.11A ** Priority 1 **

MN Rule 4626.1600A Separate poisonous or toxic materials from food, equipment, utensils, linens, and single-service and single-use articles by spacing or partitioning.

SANITIZER SPRAY BOTTLE WAS STORED ON PREP TABLE NEXT TO OPEN COFFEE CUPS. STORE SANITIZER IN A CHEMICAL STORAGE AREA.

Comply By: 12/14/21

3-500A Microbial Control: cooling

3-501.15A ** Priority 2 **

MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.

AT TIME OF INSPECTION THE FRESHLY COOKED CHOW MEIN (169 DEG F) WAS COOLING IN THE UPRIGHT COOLER WITH THE COVER TIGHTLY ON IT. USE PROPER COOLING

METHODS WHEN COOLING FOOD.
Comply By: 12/14/21

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

AT TIME OF INSPECTION TURKEY AND ROAST BEEF LUNCHMEATS WERE NOT DATEMARKED AND RAW BURGERS WERE NOT DATE MARKED.
Comply By: 12/14/21

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

PROVIDE A THERMOMETER WITH A THIN TIP (TAPERED END) TO MEASURED TEMPERATURES OF FOODS THAT ARE THIN LIKE LUNCH MEAT, BURGERS, ETC. AT TIME OF INSPECTION THERE WAS A REGULAR TIP THERMOMETER IN THE KITCHEN WHICH IS APPROVED FOR USE IN THICKER FOODS.
Comply By: 12/21/21

2-400 Hygenic Practices

2-401.11B

MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.

EMPLOYEES HAD OPEN COFFEE CUPS ON THE PREP TABLE. CONSUME BEVERAGES IN CLOSED AND COVERED CONTAINERS.
Comply By: 12/15/21

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

LABEL FLOUR AND SUGAR CONTAINERS WITH THEIR NAMES.
Comply By: 12/16/21

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12B

MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.

AT TIME OF INSPECTION THERE WAS A CONDIMENT CUP THAT WAS USED FOR DISPENSING SUGAR IN THE SUGAR BIN. PROVIDE A SCOOP WITH A HANDLE.

Comply By: 12/16/21

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

AT TIME OF INSPECTION, DINING ROOM WAS UNDER CONSTRUCTION AND THE KITCHEN STAFF WERE SERVING/PLATING FOOD IN HALLWAYS NEAR THE CONSTRUCTION ZONE. FOOD NEEDS TO BE PLATED IN THE KITCHEN AND BROUGHT TO ROOMS COVERED OR IN SINGLE-SERVICE CONTAINERS.

Comply By: 12/14/21

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

BOXES OF FOOD WERE STORED ON THE FLOOR IN THE WALK-IN FREEZER. CANNED FOOD WAS STORED ON THE FLOOR IN THE DRY STORAGE ROOM--ROOM 113. ALL FOOD MUST BE STORED UP OFF OF THE FLOOR AT LEAST 6 INCHES LIKE STATED ABOVE.

Comply By: 12/16/21

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

REMOVE CROCKPOT FROM STORAGE SHELVING IN KITCHEN. CROCKPOTS ARE NOT COMMERCIAL AND NOT APPROVED FOR USE IN COMMERCIAL KITCHENS. REPLACE WITH ANSI EQUIPMENT IF ANOTHER FOOD WARMER IS NEEDED.

Comply By: 12/21/21

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

1) REPLACE DAMAGED DOOR GASKETS ON UPRIGHT COOLER IN KITCHEN AND WALK-IN COOLER DOOR.

2) PLASTIC RACK IS HOLDING UP THE END OF THE DISHWASHING TABLE. PROVIDE APPROVED LEGS FOR THE DISHWASHING TABLE.
3) REPAIR NON-FUNCTIONAL PREP COOLER.

Comply By: 01/04/22

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

THERE WAS AN ATTACHED RACK ON THE DISHWASHER THAT WAS RESTING ON THE HANDWASHING SINK. FRESHLY WASHED DISHES WERE SITTING AND DRYING ON THE RACK AND IN THE SPLASH ZONE OF THE HANDWASHING SINK. PROVIDE A NEW RACK AWAY FROM HAND SINK OR MOVE DISHWASHER.

Comply By: 12/21/21

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

DRY STORAGE ROOM--ROOM 113: NAPKINS, CUPS, PAPER TOWELS, FOOD WRAP AND PAPER PLATES WERE STORED ON THE FLOOR. STORE ALL ITEMS UP OFF OF THE FLOOR AT LEAST 6 INCHES.

Comply By: 12/16/21

4-900 Protecting Clean Items

4-903.11B

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying, and covered or inverted.

LADLES, SPOONS AND SPATULAS NEXT TO THE STOVE NEED TO BE STORED UPSIDE DOWN WITH THE HANDLES POINTING UP. ALL UTENSILS WERE STORED WITH THE FOOD CONTACT SURFACE UP.

Comply By: 12/16/21

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

AT TIME OF INSPECTION THE PREP SINK WAS OUT OF ORDER DUE TO THE FAUCET BEING NON-FUNCTIONAL. REPLACE FAUCET AND REPAIR UNIT TO WORKING CONDITION. UNTIL UNIT IS REPAIRED, FRUITS AND VEGETABLES MUST COME IN PRE-WASHED AND PRECUT.

Comply By: 12/17/21

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

THE LINOLEUM FLOORING IN THE KITCHEN IS STAINED/NO LONGER IN GOOD REPAIR. REPLACE WITH COMMERCIAL FLOORING (e.g, QUARRY TILE,ETC.) AND INTEGRAL BASE COVE. AFTER FLOORING IS INSTALLED, PROVIDE AN APPROVED DRAIN COVER FOR DRAIN UNDER DISHWASHER TABLE.

Comply By: 01/14/22

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

THE TEMPORARY DRY STORAGE ROOM--ROOM 113 (USED DURING CONSTRUCTION) HAS CARPET FOR FLOORING. PROVIDE SMOOTH AND EASILY CLEANABLE FLOORING/BASE COVE FOR THE DRY STORAGE ROOM IF IT IS GOING TO BE USED LONGER THAN DURING CONSTRUCTION.

Comply By: 01/14/22

6-200 Physical Facility Design and Construction

6-202.14

MN Rule 4626.1390 Provide necessary walls and ceiling to completely enclose toilet rooms and a tight-fitting, self-closing device on the toilet room door.

PROVIDE A SELF-CLOSING DEVICE ON THE STAFF TOILET ROOM DOOR IN ROOM 113 (DRY STORAGE ROOM) IF THE DRY STORAGE ROOM IS USED MORE THAN JUST DURING CONSTRUCTION.

Comply By: 01/14/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.14A

MN Rule 4626.1530A Maintain clean all intake and exhaust air ducts and change filters so they are not a source of contamination.

VENTILATION HOOD FILTERS HAD SIGNIFICANT DUST BUILD UP ON THEM. MAINTAIN CLEAN.

Comply By: 12/21/21

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 165 Degrees Fahrenheit - Location: EGG ROLL
Violation Issued: No

Type: Full
Date: *12/14/21*
Time: 11:05:05
Report: 7930211210
Sunrise Village Of Milaca

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	3	15

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7930211210 of 12/14/21.

Certified Food Protection Manager Grant D. Hendrickson

Certification Number: FM100734 Expires: 09/10/22

Inspection report reviewed with person in charge and emailed.

Signed:_____ Establishment Representative

Signed:_____ Inspector ID #7930

651-201-4500
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