Electronically Delivered

August 4, 2023

Licensee
Traditions Of Waterville
117 Paquin Street East
Waterville, MN 56096

RE: Project Number(s) SL30618015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 20, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30618	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF WATERVILLE	117 PAQUIN STREET EAST WATERVILLE, MN 56096

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30618015 On June 17, 2023, through June 20, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 39 active residents; 39 receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 18, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during AM cares and catheter care for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Individualized Service Plan dated July 13, 2023, indicated the resident received services to include dressing, grooming, bathing, toileting, transfers, mobility, and medication administration. On July 18, 2023, at 7:45 a.m. unlicensed personnel (ULP)-D was observed setting up and administering medication for R6 which included oral medications and insulin. ULP-D cleansed her hands then set up R6's medications at the	0 510		

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0 510	Continued From page 3 medication cart on the first floor. Once all medications had been set-up, ULP-D then transported the medications to R6's apartment on the second floor. R6 took her oral medications and administered her eye drops independently. ULP-D then donned gloves, administered R6's insulin into the resident's abdomen, then doffed the gloves and exited R6's room. ULP-D then returned to the medication cart on the first floor, disposed of the used insulin needle from R6's insulin pen, and returned the insulin and eye drops into the medication cart. At 8:10 a.m., ULP-D went to R2's room on the first floor as the resident had been using her pendant to request assistance. ULP-D knocked on R2's apartment door then entered the resident's room; ULP-D had not washed or cleansed her hands since prior to setting up medications for R6. R2 was seated in her recliner chair utilizing her new iPad. ULP-D asked R2 if she was ready to get up and dressed, the resident responded 'yes.' ULP-D removed the blanket from R2's lap. R2's large urinary drainage bag was observed laying on the floor next to her recliner. ULP-D obtained the EZ stand (a machine that assists a person to stand up and transfer to another location) and used it to transfer R2 from her recliner into her wheelchair. ULP-D donned clean gloves, applied the sling around R2's waist and utilized the lift to transfer the resident from recliner to wheelchair with no concerns. ULP-D then hooked R2's urinary drainage bag to the sling around the resident's waist and propelled R2 into her bedroom to get dressed and use the commode. R2 stated she really didn't need to go to the bathroom and didn't want to sit on the commode. ULP-D then removed R2's sling and asked the resident what she would like to wear. R2 propelled into her closet and chose a top to wear and asked ULP-D to find her a pair of black slacks. ULP-D then	0 510		

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0 510	Continued From page 4 changed R2 out of her nightgown and assisted her with putting on a bra and top. Wearing the same gloves, ULP-D disconnected R2's large urinary drainage bag and replaced it with a leg bag. ULP-D cleansed the port of the leg bag with alcohol prior to attaching the catheter tubing, and then attached the leg bag straps around the resident's lower left leg. ULP-D then placed the large drainage bag on R2's floor by her closet. ULP-D then put on R2's pants, applied the standing lift sling around R2, and lifted her up in order to pull up R2's pants. Urine started to leak out of R2's brief and onto the seat of her wheelchair. ULP-D grabbed a chux pad to wipe up the urine, removed R2's brief and provided pericare prior to pulling up the new brief and her pants. ULP-D stated they usually had disinfectant wipes in the room, but didn't see any. ULP-D grabbed R2's skin cleanser off the dresser and used that to clean off R2's wheelchair seat. ULP-D asked R2 if she wanted to sit on a chux and the resident declined. ULP-D then lowered R2 into her wheelchair, removed her gloves and told R2 she was done and the resident could go to breakfast. ULP-D then stated she was going to empty R2's catheter drainage bag and rinse the bag with vinegar. ULP-D then doffed clean gloves and picked the bag up off the resident's floor by the closet at which point some of the urine leaked out onto the resident's carpet from the tubing. ULP-D then secured the tubing so no more urine would leak out and brought the catheter bag into the bathroom and emptied it into a graduate in order to measure the output. The surveyor asked ULP-D at what point she would cleanse her hands. ULP-D stated she would usually cleanse hands between residents, although stated she had not done that when going from R6 to R2, and should have.	0 510		

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0 510	Continued From page 5 On July 19, 2023, at 11:14 a.m. registered nurse (RN)-B stated the expectation with hand hygiene would be between resident care/contact and also with glove removal. RN-B further stated catheter bags should not be on the floor, though R2 had a habit of moving her catheter bag and placing on the floor. The licensee's Standard (Universal) Precautions for Infection Control policy dated May 27, 2022, indicated: Standard (universal) Precautions are used when coming in contact with blood; body fluids, secretions, and excretions except sweat (regardless of whether or not they contain visible blood); non-intact skin; and mucous membranes. 1. Hand washing is crucial. Staff will wash hands: - after touching blood, body fluids, feces, or contaminated items (regardless of whether or not gloves are worn) - before putting on gloves - immediately after gloves or gown are removed - as necessary, between tasks and procedures on the same resident to prevent cross-contamination of different body sites, and between all patient contacts. 2. Staff will wear clean gloves when touching blood, body fluids, feces, non-intact skin, mucus membranes, or contaminated items. Change gloves between tasks and procedures on the sesame resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, and before touching non-contaminated items, environmental surfaces, self, or other residents. Wash hands after removing gloves. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 510		

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0 510	Continued From page 6 days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to 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. 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	0 550		

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0 550	Continued From page 7 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 17, 2023, at 11:20 a.m. the surveyor toured the facility with licensed assisted living director (LALD)-A. There were postings by the front entrance that included the grievance procedure but did not include 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. At that time, LALD-A confirmed the content noted above was not posted as required. LALD-A stated that information was on the last page of the document and had not been included with the posting. The licensee's Required Postings and Disclosures policy dated July 13, 2021, identified postings required: grievance procedure (conspicuous location). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all	0 620		

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0 620	Continued From page 8 cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of two residents (R4, R5) who eloped from 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 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: R4 R4 resided on the secure memory care unit with diagnoses including dementia with Lewy bodies. R4's incident report dated June 17, 2023, at 3:00 p.m. indicated the resident eloped out of the building. The resident was visiting with a visitor while staff were going to other resident rooms to collect vital signs. R5 was no longer in the building when staff went to collect his vitals. R4's progress note dated June 17, 2023, at 20:58 (8:58 p.m.) indicated: Call received from staff at 1535 (3:35 p.m.) that resident could not be found, and he had put a note on his door stating "I left for the cabin, [resident first name]". Staff report they had last seen him about 1500 (3:00 p.m.). They think he may have left with another	0 620		

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0 620	Continued From page 9 resident's family member. Staff had searched all rooms and bathrooms. Advised staff to call police dept. (department). Stated they had and that dispatch had taken his name and birth date but did not say they would send anyone. Advised staff to call again and tell them they need to send someone. One staff member went driving around to look for resident had found the other family member driving his truck with resident in passenger seat. Notified police who were able to get resident back to facility about 1605 (4:05 p.m.). No injuries were noted. Resident was laughing and stated "it was fun". Message was left for resident's spouse about incident and staff were to notify spouse he was returned and safe. R5 R5 resided on the secure memory care unit with diagnoses including dementia with delusional disorder. R5's Annual Care Plan dated June 22, 2023, indicated: Resident is an elopement risk and may ask to go "home". R5's incident report dated June 22, 2023, at 1330 (1:30 p.m.), indicated the resident had eloped out of building utilizing her walker and was returned to the facility by a community provider. The incident report further indicated R5 had been last seen by staff at 1220 (12:20 p.m.). The resident sustained no injuries. R5's progress notes did not include information related to the resident's elopement. During the entrance conference on July 17, 2023, at 10:22 a.m. licensed assistant living director (LALD-A) stated approximately one month ago two different residents had eloped out of the	0 620		

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0 620	Continued From page 10 building from the secure memory care unit. R5 had eloped out the side door while the two staff working on the unit were assisting another resident in the shower. LALD-A stated the door she exited from was a fire door and would alarm when pushed and if remained pushed for a certain amount of time would eventually open. R5 walked down the street and was brought back to the facility by a person in the community. R4 had been talking to the husband of another resident who apparently offered to take him to his cabin. The husband had his own fob to enter and exit the building and exited the building with R4. A note was placed on R4's door to notify the staff. When staff discovered the note and realized R4 was missing, law enforcement was notified and subsequently brought the resident back to the facility. LALD-A confirmed they did not report the elopements to MAARC as the residents were not harmed. The licensee's Vulnerable Adult Maltreatment Policy dated May 27, 2022, indicated: 4. Reporting Maltreatment a. Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to their supervisor, a nurse, or the Assisted Living Director and that person will complete an incident report. a. If the incident appears to be suspected abuse, neglect or financial exploitation, the LALD or Nurse in charge will immediately make a report to the CEP (Common Entry Point). "Immediately" means as soon as possible, but no longer than 24 hours from the time the designee received initial knowledge that the incident occurred. No further information was provided.	0 620		

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0 620	Continued From page 11 TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current residents, staff, and visitors.	0 680		

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	30618	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF WATERVILLE	117 PAQUIN STREET EAST WATERVILLE, MN 56096

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0 680	Continued From page 12 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 the residents). The findings include: During the entrance conference on July 17, 2023, at 10:22 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor. The licensee's emergency preparedness plan last reviewed June 9, 2023, lacked the following required content: - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs); - document risk assessment for an all-hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community based risks (evacuation plans, staffing surges/shortages, back-up plans); - identification of at-risk population needs like maintaining independence, communication, transportation, supervision, medical care; and qualified person authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with	0 680		

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0 680	Continued From page 13 local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies; - policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal; - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing safe evacuation form facility, including care and treatment needs of evacuees; staff responsibilities; primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure addressing use of volunteers, including the process/role for integration; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - develop a written communication plan; - communication plan which includes names/contact information: staff, entities	0 680		

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0 680	Continued From page 14 providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional and local emergency management agencies; - communication plan which includes method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy, needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and - develop and maintain an EP training and testing program; - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise.	0 680		

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0 680	Continued From page 15 On July 20, 2023, at 2:54 p.m. licensed assisted living director (LALD)-A reviewed the facility Disaster Plan with the surveyor and stated the above content was missing. LALD-A further stated they did not review the Missing Person policy quarterly as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 690 SS=E	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the title of the person making the entry for three of three residents (R2, R3, R4). 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	0 690		

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0 690	Continued From page 16 found to be pervasive). The findings include: R2 R2's 30 Day Filled MAR (medication administration record) dated July 1, 2023, through July 17, 2023, had a list of staff identified (that had administered medications) at the bottom of the last page with columns for name/title and initials. 15 staff initials and names were identified; however, titles were lacking on 11 of the identified staff members. R2's 30 Day Filled TAR (treatment administration record) dated July 1, 2023, through July 17, 2023, had a list of staff identified (that had completed treatments) at the bottom of the last page with columns for name/title and initials. 11 staff initials and names were identified; however, titles were lacking on seven of the identified staff members. R2's ADL (activities of daily living) Flowsheet dated July 1, 2023, through July 17, 2023, had a list of staff identified (that had assisted with ADLs) at the bottom of the last page with columns for name/title and initials. 14 staff initials and names were identified; however, titles were lacking on 11 of the identified staff members. R3 R3's 30 Day Filled MAR dated July 1, 2023, through July 17, 2023, had a list of staff identified (that had administered medications) at the bottom of the last page with columns for name/title and initials. 20 staff initials and names were identified; however, titles were lacking on 14 of the identified staff members. R3's 30 Day Filled TAR dated July 1, 2023,	0 690		

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0 690	Continued From page 17 through July 17, 2023, had a list of staff identified (that had completed treatments) at the bottom of the last page with columns for name/title and initials. 12 staff initials and names were identified; however, titles were lacking on nine of the identified staff members. R3's ADL Flowsheet dated July 1, 2023, through July 17, 2023, had a list of staff identified (that had assisted with ADLs) at the bottom of the last page with columns for name/title and initials. 18 staff initials and names were identified; however, titles were lacking on 13 of the identified staff members. R4 R4's 30 Day Filled MAR dated July 1, 2023, through July 17, 2023, had a list of staff identified (that had administered medications) at the bottom of the last page with columns for name/title and initials. 16 staff initials and names were identified; however, titles were lacking on 11 of the identified staff members. R4's 30 Day Filled TAR dated July 1, 2023, through July 17, 2023, had a list of staff identified (that had completed treatments) at the bottom of the last page with columns for name/title and initials. Three staff initials and names were identified; however, titles were lacking on one of the identified staff members. R4's ADL Flowsheet dated July 1, 2023, through July 17, 2023, had a list of staff identified (that had assisted with ADLs) at the bottom of the last page with columns for name/title and initials. 14 staff initials and names were identified; however, titles were lacking on ten of the identified staff members.	0 690		

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0 690	Continued From page 18 On July 19, 2023, at 11:14 a.m. registered nurse (RN)-B stated not all unlicensed staff's titles were included on R2, R3, and R4's MAR, TAR, and ADL Flowsheets. RN-B further stated this would be consistent for all residents in the facility. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated July 13, 2021, indicated: 1. Staff will document each task immediately after that task has been performed. 2. Documentation will follow professional standards for documentation, including the requirement that entries must be: a. Legible; b. Permanently recorded in black/blue ink or in electronic form; c. Dated with the time of entry; d. Authenticated with the name and title of the person making the entry. When initials are used by persons making entries in the client record, the person will authenticate initials with a full signature and title. The signature and title may be included on the same document or on the EMR (electronic medical record). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of	0 730		

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0 730	Continued From page 19 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 (15) other documentation required under this chapter and relevant to the resident's services or	0 730		

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0 730	Continued From page 20 status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R1 was admitted to the licensee on January 9, 2023, with diagnoses including osteoarthritis of bilateral shoulders and hips, heart failure, and depression. On July 19, 2023, at 11:14 a.m. registered nurse	0 730		

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0 730	Continued From page 21 (RN)-B stated R1's discharge summary did not include all required content. The licensee's Discharge Summary policy dated May 27, 2022, indicated: 4. The discharge summary will include, if applicable, a. Summary of the resident's stay, including i. Diagnosis ii. Courses of illnesses iii. Allergies iv. Treatments v. Therapies vi. Pertinent lab results vii. Pertinent radiology results viii. Pertinent consultation results ix. Final summary of the resident's status. The summary will be based upon the latest assessment or review and, if applicable, will include resident status including baseline and current mental, behavioral, and functional status. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On facility tour with the Licensed Assisted Living Director (LALD)-A, between approximately 9:00 AM and 1:00 PM on July 18, 2023, it was observed that the laundry rooms (2) needed maintenance to remove accumulations of lint. This was specifically noted in the areas behind the dryers and other hard-to-reach areas of the room. This deficient condition was visually verified by LALD-A accompanying on the tour. Additionally, within the memory care area of the facility, it was observed that the bathroom vent needed servicing as it was coming loose from the wall. This deficient condition was visually verified by LALD-A accompanying on the tour. It also was observed within the memory care area, that there were unsecured utensils and	0 800		

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0 800	Continued From page 23 chemicals within the kitchen. These items are required to be in secure areas within the memory care to prevent the occurrence of potential injury to those in the facility. This deficient condition was visually verified by LALD-A accompanying on the tour. Additionally, it was observed that many of the emergency exit signs and emergency lights did not activate when tested during the tour. LALD-A was educated on the process as the maintenance person had recently left employment. This deficient condition was visually verified by LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique 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.	0 810		

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0 810	Continued From page 24 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide training to residents capable of assisting in their own evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on July 18, 2023, between approximately 12:30 p.m. and 1:00 p.m. with the Licensed Assisted Living	0 810		

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0 810	Continued From page 25 Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not provide annual training on proper actions to take in the event of a fire or similar emergency to residents who are capable of self-evacuation. Record review of available documentation indicated that the licensee did not conduct fire safety and evacuation drills for employees twice per year per shift with at least one drill conducted every other month. During interview LALD-A provided a policy that stated that fire safety and evacuation drills were to be conducted every month, however could not provide documentation that these drills had occurred. These deficient conditions were verified by LALD-A during interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 980 SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law.	0 980		

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0 980	Continued From page 26 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident agreement arbitration requirement did not include a choice of venue provision. This practice resulted in a level one violation and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated, Residency Agreement used for all residents, included a section titled, V. Arbitration and Limitation of Liability Provision; section A, titled Arbitration Provision, number three, indicated: 3. The arbitration proceedings shall take place in the county in which the Residence is located, unless agreed to otherwise by mutual consent of the parties. On July 19, 2023, at 10:30 a.m. licensed assistant living director (LALD)-A stated arbitration language dictating the venue was part of all residents' contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 980		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500		

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01500	Continued From page 27 for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01500		

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01500	Continued From page 28 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (registered nurse (RN)-F). 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: RN-F began providing direct care and on-call services, on August 1, 2021, under the licensee's assisted living with dementia care license. RN-F's employee record lacked evidence the	01500		

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01500	Continued From page 29 employee had successfully completed annual training to include the following: -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On July 20, 2023, at 12:08 p.m. licensed assistant living director (LALD)-A stated staff had not been consistently reviewing policies and procedures annually. LALD-A further stated RN-F's record indicated facility policies and procedures were last reviewed July 14, 2021. The licensee's Assisted Living Annual Training policy dated May 27, 2022, indicated: 1. All assisted living employees will complete annual education on the following topics: g. Review of policies and procedures relating to the provision of assisted living services and how to implement them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620		

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01620	Continued From page 30 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) had completed and/or documented a comprehensive assessment to include required areas of assessment per Assisted Living Facilities: Minnesota Rules Chapter 4659, for three of three residents (R2, R3, R4) and failed to ensure the RN completed comprehensive reassessment and monitoring every 90 days as required for one of three residents (R4). 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).	01620		

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01620	Continued From page 31 The findings include: R2 R2's diagnoses included dislocated left elbow, osteoarthritis, hypertension (high blood pressure), and depression. R2 was discharged from hospice services on July 13, 2023. R2's Individualized Service Plan dated July 13, 2023, indicated the resident received services to include dressing, grooming, bathing, toileting/catheter care, transfers, mobility, and medication administration. On July 18, 2023, at 8:10 a.m. unlicensed personnel (ULP)-D was observed assisting R2 with morning cares. R2's last three RN assessments were requested. The assessments were dated May 3, 2023, May 30, 2023, and July 17, 2023. The assessments did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components required in subpart 2, section A, 1-3. R3 R3's diagnoses included dementia, obsessive compulsive disorder, and attention deficit disorder. R3's Individualized Service Plan dated May 25, 2023, indicated R3 received services which included bathing, grooming, dressing, toileting, treatments, and medication administration. On July 18, 2023, at 8:49 a.m. ULP-E was observed prompting R3 for the breakfast meal. R3 was in his room in bed and did not want to get up at that time. ULP-E informed R3 she would	01620		

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01620	Continued From page 32 return in 30 minutes to see if he was ready to get up for the day. R3's last three RN assessments were requested. The assessments were dated May 26, 2023, May 1, 2023, and January 31, 2023. The assessments did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components required in subpart 2, section A, 1-3. R4 R4's diagnoses included Lewy body dementia and REM (rapid eye movement) sleep disorder (sleep disorder in which the patient acts out the dreams through limb movements and talking). R4's Individualized Service Plan dated July 13, 2022, indicated R4 received services which included bathing, dressing and grooming reminders, and medication administration. R4's last three RN assessments were requested. The assessments were dated June 7, 2023, March 7, 2023, and February 14, 2023. The assessments did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components required in subpart 2, section A, 1-3. In addition, R4's most recent assessment date June 7, 2023, was completed 92 days after the previous assessment dated March 7, 2023. On July 20, 2023, at 12:44 p.m. the surveyor reviewed the Minnesota Rules Chapter 4659.0150 with RN-B related to required components in the Uniform Assessment Tool. RN-B stated the above assessments for R2, R3, and R4 did not contain all required components and further stated using the same assessments	01620		

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01620	Continued From page 33 for all residents. RN-B further stated R4's last 90-day assessment was completed late. The Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool indicated: - Subpart 1. Definition. For purposed of this part, "Uniform Assessment Tool" means an assessment tool that meets the requirements of this part and is used by a licensee to comprehensively evaluate a resident's or prospective resident's physical, mental, and cognitive needs - Subp. 2. Assessment tool elements. Each facility must develop a uniform assessment tool. The facility may use any acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. A uniform assessment tool must address the following: A. the resident's personal lifestyle preferences, including: (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; (2) spiritual and cultural preferences; and (3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order or "physician/provider orders for life-sustaining treatment: order. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy dated July 13, 2021, indicated: 1. A RN will complete the following	01620		

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01620	Continued From page 34 comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: complete up to 14-days after start of services c. Ongoing assessment completed periodically but no less than every 90-days d. Change in resident condition 2. A RN will complete assessments as indicated by individual resident circumstances 3. A comprehensive assessment includes buy may not be limited to the requirements outline by Minnesota rules. Current and historical records and information are reviewed to the extent they are made available to the RN and if the RN is aware of these records. Comprehensive assessment will include: a. The residents personal lifestyle preference, including: i. Sleep schedule, dietary and social needs, leisure activities, and other customary routines that are important to the resident's quality of life; ii. Spiritual and cultural preferences Advanced health care directives and end-of-life preference, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life sustaining treatment" order. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 35 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were kept in the original container bearing the original prescription label for two of two residents (R6, R7) who received insulin. 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: R6 R6's diagnoses included diabetes mellitus. R6's Service Plan dated May 24, 2023, indicated the resident received assistance with medication administration. R6's signed physician orders dated July 13, 2023, included an order for Humalog KwikPen insulin 100 unit/ml (units per milliliter) injection. Inject 6 units subcutaneously (under the skin) every morning before breakfast plus correction scale.	01890		

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01890	Continued From page 36 On July 18, 2023, at 7:45 a.m. unlicensed personnel (ULP)-D was observed preparing R6's Humalog insulin pen for administration. The surveyor noted there was no prescription label on the pen. ULP-D confirmed there was not a prescription label on the pen or in the medication cart. ULP-D stated she went by the electronic medication administration record (eMAR) for the dosing instructions. ULP-D then proceeded to administer the insulin to R6. R7 R7's diagnoses included diabetes mellitus. R7's Individualized Service Plan dated May 5, 2023, indicated the resident received assistance with medication administration. R7's physician orders printed July 13, 2023, included an order Novolog FlexPen. Inject 50 units twice daily with lunch & supper plus sliding scale up to 200 units per day. *If not eating hold and just use sliding scale; correction: three units per 50 mg/dl (milligrams per deciliter) starting at 150 up to 20 units extra*. On July 18, 2023, at 11:53 a.m. ULP-H was observed preparing R7's Novolog insulin pen for administration. The surveyor noted there was no prescription label on the pen. ULP-I (who was training ULP-H) stated there was not a prescription label on the pen or in the medication cart. ULP-H stated the insulin pens come in a baggie with the pharmacy label attached, but they throw the baggie away and refer to the eMAR. ULP-I then proceeded to administer R7's insulin. On July 19, 2023, at 11:14 a.m. registered nurse (RN)-B confirmed staff should be keeping the	01890		

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01890	Continued From page 37 pharmacy label for the resident insulin pens in the medication cart. The licensees's Storage of Medications policy dated March 11, 2015, indicated: 2. b. Until the medication is set up for immediate or later administration by an nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date or time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 38 (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 interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 17, 2023, at 10:22 a.m. registered nurse (RN)-B stated the licensee provided treatment management services to residents, including compression	01940		

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01940	Continued From page 39 stockings, and assistance with CPAP (continuous positive airway pressure) machines. R3 R3's Individualized Service Plan (ISP) dated May 25, 2023, included assistance with TED (thrombo-embolic-detterent) hose/support stockings two times daily with AM and HS (hour of sleep/bedtime) cares. The ISP directed staff to put on in the morning, take off at night and hand wash/hang dry. R3's ISP also included assistance with CPAP machine. The ISP directed staff to put on at night, check every two hours for placement, and take off during the day. R3's Significant Change Care Plan dated May 26, 2023, indicated R3 required assistance with dressing, mostly lower body, TEDs, socks, shoes, etc. The care plan further indicated staff were to check R3's CPAP machine every night to ensure filled with distilled water and to check resident every two hours while sleeping to ensure placement. R3's ADL Flowsheet dated July 2023, included assist of one staff with dressing twice daily, CPAP and distilled water check daily, and CPAP safety checks four times during the night. R3's records lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services On July 19, 2023, at 2:35 p.m. registered nurse (RN)-B indicated resident's care plans provided direction for staff related to treatment procedures. RN-B reviewed R3's medical record and could	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30618	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 40 not find evidence directing unlicensed personnel of when to notify a nurse related to R3's TED stockings and CPAP machine. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior;	02170		

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02170	Continued From page 41 (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions, and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R3, R4) who received services under an assisted living with dementia care license and resided in the secure memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license, effective August 1, 2022. R3 R3's diagnoses included dementia, obsessive compulsive disorder, and attention deficit disorder.	02170		

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02170	Continued From page 42 R3's Individualized Service Plan dated May 25, 2023, indicated R3 received services which included bathing, grooming, dressing, toileting, treatments, and medication administration. On July 18, 2023, at 8:49 a.m. unlicensed personnel (ULP)-E was observed prompting R3 for the breakfast meal. R3 was in his room in bed and did not want to get up at that time. ULP-E informed R3 she would return in 30 minutes to see if he was ready to get up for the day. R3's undated, activity assessment titled, Life Enrichment Story, lacked the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R3's record did not include evidence of an individualized activity plan based on the resident's activity assessment. R4 R4's diagnoses included Lewy body dementia and REM (rapid eye movement) sleep disorder (sleep disorder in which the patient acts out the dreams through limb movements and talking). R4's Individualized Service Plan dated July 13, 2022, indicated R3 received services which included bathing, dressing and grooming reminders, and medication administration. On July 17, 2023, at 3:29 a.m. R4 was observed outside with staff within the secured outdoor patio off the secure memory care unit.	02170		

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02170	Continued From page 43 R4's undated, activity assessment titled, Life Enrichment Story, lacked the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R4's record did not include evidence of an individualized activity plan based on the resident's activity assessment. On July 20, 2023, at 12:49 p.m. activity director (AD)-G stated the Life Enrichment Story was the only activity assessment completed for assisted living and memory care residents. AD-G reviewed the required components needed and stated the assessment did not include all the required information. AD-G further state not having an activity plan for the memory care residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a	03000		

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03000	Continued From page 44 vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this	03000		

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03000	Continued From page 45 information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of two residents (R4, R5) who eloped from 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 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: R4 R4 resided on the secure memory care unit with diagnoses including dementia with Lewy bodies. R4's incident report dated June 17, 2023, at 3:00 p.m. indicated the resident eloped out of the building. The resident was visiting with a visitor while staff were going to other resident rooms to collect vital signs. R5 was no longer in the building when staff went to collect his vitals. R4's progress note dated June 17, 2023, at 20:58 (8:58 p.m.) indicated: Call received from staff at 1535 (3:35 p.m.) that resident could not be found, and he had put a note on his door stating "I left for the cabin, [resident first name]". Staff report they had last seen him about 1500 (3:00 p.m.).	03000		

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03000	Continued From page 46 They think he may have left with another resident's family member. Staff had searched all rooms and bathrooms. Advised staff to call police dept. (department). Stated they had and that dispatch had taken his name and birth date but did not say they would send anyone. Advised staff to call again and tell them they need to send someone. One staff member went driving around to look for resident had found the other family member driving his truck with resident in passenger seat. Notified police who were able to get resident back to facility about 1605 (4:05 p.m.). No injuries were noted. Resident was laughing and stated "it was fun". Message was left for resident's spouse about incident and staff were to notify spouse he was returned and safe. R5 R5 resided on the secure memory care unit with diagnoses including dementia with delusional disorder. R5's Annual Care Plan dated June 22, 2023, indicated: Resident is an elopement risk and may ask to go "home". R5's incident report dated June 22, 2023, at 1330 (1:30 p.m.), indicated the resident had eloped out of building utilizing her walker and was returned to the facility by a community provider. The incident report further indicated R5 had been last seen by staff at 1220 (12:20 p.m.). The resident sustained no injuries. R5's progress notes did not include information related to the resident's elopement. During the entrance conference on July 17, 2023, at 10:22 a.m. licensed assistant living director (LALD-A) stated approximately one month ago	03000		

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03000	Continued From page 47 two different residents had eloped out of the building from the secure memory care unit. R5 had eloped out the side door while the two staff working on the unit were assisting another resident in the shower. LALD-A stated the door she exited from was a fire door and would alarm when pushed and if remained pushed for a certain amount of time would eventually open. R5 walked down the street and was brought back to the facility by a person in the community. R4 had been talking to the husband of another resident who apparently offered to take him to his cabin. The husband had his own fob to enter and exit the building and exited the building with R4. A note was placed on R4's door to notify the staff. When staff discovered the note and realized R4 was missing, law enforcement was notified and subsequently brought the resident back to the facility. LALD-A confirmed they did not report the elopements to MAARC as the residents were not harmed. The licensee's Vulnerable Adult Maltreatment Policy dated May 27, 2022, indicated: 4. Reporting Maltreatment a. Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to their supervisor, a nurse, or the Assisted Living Director and that person will complete an incident report. a. If the incident appears to be suspected abuse, neglect or financial exploitation, the LALD or Nurse in charge will immediately make a report to the CEP (Common Entry Point). "Immediately" means as soon as possible, but no longer than 24 hours from the time the designee received initial knowledge that the incident occurred. No further information was provided.	03000		

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03000	Continued From page 48 TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

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

Type: Full
Date: *07/18/23*
Time: 11:43:03
Report: 1028231097

Food and Beverage Establishment Inspection Report

Location:
Traditions Of Waterville
117 Paquin Street East
Waterville, MN56096
Le Sueur County, 40

Establishment Info:
ID #: 0037921
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073624155
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Sausage and tuna in the Migali refrigerator were measured at 43 and 44 degrees F, respectively. Ensure that all TCS foods are being held at 41 degrees F or below at all times. The temperature of the Migali refrigerator must be turned down immediately.

Comply By: 07/18/23

3-800 Highly Susceptible Populations

3-801.11B ***** Priority 1 *****

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

Discontinue using unpasteurized eggs in the preparation of recipes in which more than 1 egg is broken and the eggs are combined.

Provide pastuerized eggs.

Comply By: 07/18/23

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose

particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

Discontinue thawing hot dogs by placing them in room temperature water. Hot dogs, and other TCS food items, must be thawed using one of the above listed methods.

Comply By: 07/18/23

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

The top of the interior of the microwave must be cleaned to remove food residue build-up.

Comply By: 07/18/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

Dust on the ceiling of the kitchen area must be removed. Ensure that the ceiling is being cleaned regularly to prevent this accumulation in the future.

Comply By: 08/01/23

Surface and Equipment Sanitizers

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

Chlorine: = 50ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 188 Degrees Fahrenheit - Location: Ham
Violation Issued: No

Process/Item: Hot Holding
Temperature: 190 Degrees Fahrenheit - Location: Gravy
Violation Issued: No

Process/Item: Cold Holding
Temperature: 43 Degrees Fahrenheit - Location: Sausage
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 44 Degrees Fahrenheit - Location: Tuna
Violation Issued: Yes

Type: Full
Date: *07/18/23*
Time: 11:43:03
Report: 1028231097
Traditions Of Waterville

Food and Beverage Establishment Inspection Report

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

This Inspection was conducted in conjunction with HRD.

Fire Extinguishers in the kitchen area were last serviced in June 2022. Ensure that they are being serviced at least once every 12 months.

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 1028231097 of 07/18/23.

Certified Food Protection Manager: Jessica Schroeder

Certification Number: FM46983 Expires: 01/18/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Beth Clinton
Culinary Manager

Signed: _____

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