Electronically Delivered

November 18, 2022

Administrator
Edgewood Alexandria Senior Living
1902 7th Avenue East
Alexandria, MN 56308

RE: Project Number(s) SL30729015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 2, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

REQUESTING A HEARING

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

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30729	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD ALEX SENIOR LIVING	1902 7TH AVENUE EAST ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30729015 On, October 31, 2022, through November 2, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 56 residents receiving services under the provider's Assisted Living with Dementia Care 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This 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 October 31, 2022, at 2:18 p.m., executive director (ED)-A stated she was in the process of obtaining her LALD license and identified LALD-L as the facility's current LALD. The Board of Executives for Long-Term Services and Support (BELTSS) website was reviewed with registered nurse (RN)-C. The BELTSS website indicated LALD-L held a current assisted living director license (issued June 28, 2021; and expires October 31, 2023). The website did not list LALD-L as the Director of Record for the licensee, this section was left blank.	0 110		

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0 110	Continued From page 2 On November 2, 2022, at 12:45 p.m., LALD-L stated she took over as the LALD-L for the facility on September 26, 2022. LALD-L stated the corporate office was responsible for updating the BELTSS website and she was aware she was not listed as the Director of Record for the facility. The licensee's undated Applying for Assisted Living Director Licensure policy noted an Assisted Living Director is the person who administers, manages, supervises, or is in general administrative charge of the assisted living facility. There must be one designated LALD as the Director of Record for each Minnesota assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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	0 250		

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0 250	Continued From page 3 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 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	0 250		

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0 250	Continued From page 4 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 om October 31, 2022, at 2:34 p.m., registered nurse (RN)-C and executive director (ED)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication 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	0 250		

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0 250	Continued From page 5 [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 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,	0 250		

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0 250	Continued From page 6 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 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 (O)-M on May 10, 2021. The licensee had an assisted living license issued	0 250		

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0 250	Continued From page 7 on August 1, 2022, with an expiration date of April 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (2) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (3) infection control practices; (4) 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; (5) medication and treatment management; and (6) supervision of unlicensed personnel performing delegated tasks. On November 2, 2022, at approximately 4:15 p.m., RN-C confirmed the licensee conducted orientation, training and competency evaluations of staff, and a process for evaluating staff performances, conducted assessments, provided medication and treatment management services, followed infection control practices, conducted staff screenings for TB and supervised ULP performing delegated tasks but failed to implement corresponding policies and procedures, as required. but failed to implement corresponding policies and procedures, as required.	0 250		

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0 250	Continued From page 8 As a result of this survey, the following orders were issued 0110, 0470, 0480, 0485, 0510, 0640, 0680, 0800, 0950, 1350, 1440, 1470, 1620, 1640, 1710, 1760, 1790, 1890, 1940, 2110, 2320, 2410, 3070 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. 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	0 470		

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0 470	Continued From page 9 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 and interview, the licensee failed to ensure the staffing plan was posted in the memory care unit, potentially affecting 21 of the licensee's current 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 October 31, 2022, at 2:48 p.m., during a tour of the facility, the surveyor did not observe a posted staff schedule in the secured memory care unit. On October 31, 2022, at 3:30 p.m., executive director (ED)-A stated the staffing schedule was only posted in the main entry and not posted for residents, staff, and visitors to be able to access in the secure memory care unit. ED-A stated the memory care unit does have its own separate entrance which can be used by visitors and staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 470		

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0 470	Continued From page 10 (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced 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).	0 480		

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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
0 480	Continued From page 11 The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 1, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post a menu a week in advance that was	0 485		

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	30729	A. BUILDING: _____ B. WING _____	11/02/2022

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0 485	Continued From page 12 made available to all residents. This had the potential to affect all 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 November 2, 2022, at 10:00 a.m., the surveyor observed posted in both the assisted living unit and memory care unit the breakfast, lunch, and dinner menu for the current day. On November 2, 2022, at 10:54 a.m., registered nurse (RN)-C stated they have a "rotating seasonal" menu the cooks go by when preparing meals. RN-C stated they usually post on the same information board in the dining room area a listing of the activities for the day and the menu for the day. RN-C confirmed only the daily menu was posted and not a weekly menu. The licensee's Food Service and Menu Planning policy dated October 1, 2021, noted menus would be prepared at least one week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		

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0 510	Continued From page 13	0 510		
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 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 ensure infection control standards were followed for one of one unlicensed personnel (ULP-H) during blood pressure monitoring for 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 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 November 1, 2022, at 9:04 a.m., the surveyor observed ULP-H go to a staff room, open a bag which belonged to ULP-H and remove a small pink bag and take the pink bag to R4's room.	0 510		

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0 510	Continued From page 14 ULP-H unzipped the pink bag and removed a stethoscope and a manual blood pressure machine. ULP-H placed the stethoscope around her neck and into her ears. ULP-H placed the blood pressure cuff around R4's upper left arm. ULP-H took R4's blood pressure and stated it was "a little low." ULP-H removed the blood pressure cuff from R4's arm and put the blood pressure cuff and stethoscope into the pink bag and zipped it up. ULP-H administered R4's morning medications and took the pink bag with her, placing the pink bag on top of the medication cart. The surveyor did not observe ULP-H sanitize the blood pressure cuff anytime during the observation. Directly following the above observation ULP-H stated "I promise I will clean it (blood pressure cuff) when I put it back in my bag. That is what I normally do." On November 1, 2022, registered nurse (RN)-C stated the blood pressure cuff was to be cleaned after each use. The licensee's undated Cleaning of Shared Medical Equipment policy indicated in accordance with existing infection prevention and control policies and procedures. The facility would implement and maintain processes to ensure all reusable resident care equipment was routinely cleaned, and when appropriate, disinfected, before and after reused. Common shared resident care equipment may include: stethoscopes, blood pressure cuffs, thermometers, pulse oximeter (device placed on finger to estimate the oxygen saturation of blood), and glucometer (testing blood sugar level.) No further information was provided.	0 510		

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0 510	Continued From page 15 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 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 required content to include the 911 emergency number in common areas and near telephones provided by the assisted living. This had the potential to affect all 56 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).	0 640		

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0 640	Continued From page 16 The findings include: On October 31, 2022, at 3:16 p.m., the surveyor toured the facility with registered nurse (RN)-C and executive director (ED)-A. The surveyor did not observe the 911 emergency number posted in common areas or near telephones provided by the assisted living facility. On October 31, 2022, at 3:50 p.m., RN-C stated there were two cordless telephones for resident use, one in the memory care unit by the medication cart and one in the nursing office in the assisted living unit. RN-C stated the 911 emergency number was not posted on or near either of these cordless telephones or in the common area. RN-C was unaware of this requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
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;	0 680		

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0 680	Continued From page 17 (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 develop a written emergency preparedness plan (EPP) with all the required content and failed to post an EPP prominently. This had the potential to affect all residents, staff, and visitors 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), 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 October 31, 2022, at 2:40 p.m., the surveyor asked for the licensee's EPP, which was provided to and later reviewed by the surveyor.	0 680		

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0 680	Continued From page 18 On October 31, 2022, at 2:48 p.m., a facility tour was conducted with executive director (ED)-A. There was no observed signage posted or information regarding the licensee's EPP in the common areas of the facility. The licensee's plan provided to the surveyor included an undated hazard vulnerability assessment (HVA) which noted 45 events (such as tornado, blizzard, elopement, fire, power outage, pandemic etc.) and scored each event based on probability, risk, and preparedness levels. In addition, the HVA included identification of geographical hazardous areas (such as a busy road, pipeline, and bodies of water) and indicated the proximity of the potential hazard to the facility and identified if it was a potential hazard. The EPP included basic direction for the staff to follow in the case of a fire, tornado, evacuation, and power outage. It also included some emergency contact names and numbers, and agreements with nearby churches to use as relocation sites in case an evacuation was needed. The licensee's EPP did not include the following content: - a description of the population served by the licensee to identify at risk populations - process for EP corporation with state and local EP officials/organizations - the development of policies and procedures to address: - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems) - shelter in place to meet the needs of the	0 680		

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0 680	Continued From page 19 residents - a medical record documentation system to preserve resident information, security, and availability - A communication plan that included: - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies - a method of sharing information and medical documentation for residents information about their occupancy; and - a method of sharing information from the EPP with residents and their families. On October 31, 2022, at 3:25 p.m., ED-A stated the EPP binder could be found in each nursing office and in the director's office. ED-A stated the EPP was not posted in the common areas of the facility. On November 2, 2022, at 9:28 a.m., ED-A stated she was somewhat familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). ED-A and licensed assisted living director (LALD)-L stated they thought they had discussed needing some of the items listed above but knew the EPP was a work in progress. The licensee's undated Emergency Preparedness policy noted the licensee's EPP will include all required elements of appendix Z. The plan will be in writing and reviewed annually.	0 680		

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0 680	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding 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 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 the potential to affect a large portion or all residents). The findings include: On November 01, 2022, from approximately 10:45 a.m. to 12:45 p.m., survey staff toured the facility with Maintenance Director (MD)-K. During	0 800		

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0 800	Continued From page 21 the facility tour, survey staff observed and verified that some of the resident rooms, both in the independent and memory care units, had their fire rated doors propped open . MD-K verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 950 SS=C	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident	0 950		

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0 950	Continued From page 22 must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure four of four residents (R2, R3, R4, R5) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. This had the potential to affect all 56 residents who received services at the facility. 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: R2 R2's service plan dated August 9, 2022, indicated R2 received services to include medication administration, housekeeping, laundry and assistance with dressing, hygiene, showering, transferring and toileting. R2's Residency Agreement signed August 3, 2021, included the name and contact information of R2's designated representative. R3	0 950		

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0 950	Continued From page 23 R3's service plan dated July 29, 2021, indicated R3 received services to include medication administration, glucose monitoring, housekeeping, laundry, and assistance with showering, dressing, toileting, and grooming. R3's Residency Agreement signed July 29, 2021, included the name and contact information of R3's designated representative. R4's R4's service plan dated September 12, 2022, indicated R4 received services to include medication administration, catheter (tube placed in the body to drain and collect urine from the bladder) care, vital sign monitoring, housekeeping, laundry and assistance with dressing, hygiene, showering, transferring and toileting. R4's service plan signed September 12, 2022, included place for R4 to decline a designated representative or name one, which was left blank. R5's R5's service plan dated October 25, 2022, indicated R5 received services to include medication administration, anti-embolism hose (compression), vital sign monitoring, housekeeping, laundry and assistance with dressing, hygiene, showering, transferring and toileting. R5's service plan signed November 1, 2022, included place for R4 to decline a designated representative or name one, which was left blank. R2, R3, R4, R5's record lacked evidence of a notice with the required statutory language for the resident to have the opportunity to identify a	0 950		

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0 950	Continued From page 24 designated representative or documentation that R2, R3, R4, R5 declined to name a designated representative. On November 2, 2022, at 3:49 p.m., registered nurse (RN)-C stated they do not have a specific form with the required language on it for residents to have the opportunity to identify or decline to name a designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01350 SS=F	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 observation, interview and record review, the licensee failed to ensure contracted staff met all requirements required for personnel employed by the licensee for one of one contracted unlicensed personnel (ULP)-J. 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).	01350		

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01350	Continued From page 25 The findings include: ULP-J was contracted by the licensee, and started at the facility on September 1, 2022, to provide direct care services to residents of the assisted living facility. On November 1, 2022, at 6:47 a.m., the surveyor observed ULP-J administer R5's morning medication. ULP-J's employee record lacked evidence ULP-J had received training on the following required topics: Orientation Training: (1) an overview of assisted living statutes; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (5) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (6) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (7) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	01350		

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	30729	A. BUILDING: _____ B. WING _____	11/02/2022

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01350	Continued From page 26 ULP-Js employee record also lacked evidence ULP-J had completed the second step of the two-step tuberculin skin test as required. On November 2, 2022, at 3:01 p.m., registered nurse (RN)-C confirmed ULP-J had not completed the above-mentioned topics, "if it is not in her record, we don't have it." RN-C stated all of the agency staff used at the facility would be lacking these topics. RN-C added the agency used requires that their staff have one hour of orientation at the facility and to the residents prior to working. On November 2, 2022, at 3:15 p.m., RN-C confirmed ULP-J did not complete the required second step of the tuberculin skin test (Mantoux). On November 4, 2022, at 11:01 a.m., RN-C stated the facility does not have a "certain" number of agency staff they use, adding some agency staff might work there one time and others who live close might work there more often. The licensee's undated Orientation of Staff and Supervisors policy noted all employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain an overview of the appropriate assisted living statutes and rules, and a review of the types of assisted living services the employee will be providing and the facility's category of licensure. The licensee's undated Tuberculosis Screening policy indicated new staff would have a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for health care workers (HCW)s.	01350		

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01350	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350		
01440 SS=D	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 observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the	01440		

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01440	Continued From page 28 date on which the individual begins working for the licensee for one of one unlicensed personnel (ULP)-B. 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 November 1, 2022, at 7:21 a.m., the surveyor observed ULP-B apply R9's compression stockings (specialized hosiery that are used to improve the blood flow in the veins of your legs). ULP-B was hired on July 7, 2021, to provide direct care for the licensee's residents. ULP-B's employee record did not include documentation of a registered nurse (RN) supervising ULP-B performing a delegated task within 30 days of beginning work with the licensee. On November 2, 2022, at 2:04 p.m., RN-C stated ULP-B's 30-day supervision of performing a delegated task had not been completed as required. The licensee's undated Supervision of Licensed and Unlicensed Personnel Policy noted direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our agency and has been trained and determined	01440		

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01440	Continued From page 29 competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470		

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01470	Continued From page 30 other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of three employees (unlicensed personnel) ULP-B. 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	01470		

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01470	Continued From page 31 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on July 7, 2021, to provide direct care to residents at the assisted living facility. On November 1, 2022, at 7:21 a.m., the surveyor observed ULP-B apply R9's compression stockings (specialized hosiery that are used to improve the blood flow in the veins of your legs). ULP-B's employee record did not include the following required orientation content: - an overview of the 144G statutes, and - a review of the types of assisted living services the employee will be providing and the facility's category of license. On November 2, 2022, at 3:53 p.m., registered nurse (RN)-C stated the above noted assisted living orientation had not been completed for ULP-B. The licensee's undated Orientation of Staff and Supervisors policy noted all employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain an overview of the appropriate assisted living statutes and rules, and a review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01470		

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01470	Continued From page 32 (21) days	01470		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment to include an assessment of current smoking status for one of five residents (R16).	01620		

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01620	Continued From page 33 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: R16's diagnoses included sepsis (body's extreme response to an infection, life threatening medical emergency, when an infection triggers a chain reaction through the body), chronic kidney disease (CKD-mild to moderate damage, kidneys are less able to filter waste and fluid out of blood), chronic obstructive pulmonary disease (COPD-a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), diabetes, nicotine dependence, cigarettes/uncomplicated, hypertension (HTN-high blood pressure), and alcohol abuse in remission. R16's service plan dated March 31, 2022, indicated R16 received services to include medication administration, behavior monitoring, vital sign monitoring, housekeeping, laundry and assistance with dressing, hygiene, showering, transferring and toileting. R16's assessment dated October 21, 2022, included a section titled "Safe Smoking: Smoking assessment is not applicable." On November 2, 2022, at 8:45 a.m., the surveyor observed R16 sitting in a wheelchair positioned behind a wood panel smoking a cigarette. R16	01620		

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01620	Continued From page 34 stated he goes "out here" every morning after breakfast for a cigarette. On November 2, 2022, at 9:45 a.m., RN-C stated, "well, that [assessment] is not correct, he [R16] smokes." The licensee's undated Assessments, Reviews & Monitoring policy indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan.	01640		

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01640	Continued From page 35 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of four residents (R15) service plan was revised to include provided 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 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 October 31, 2022, at approximately 2:10 p.m., registered nurse (RN)-C stated the licensee provided medication management services to include medication setup. R15's diagnoses included Alzheimer's dementia. R15's service plan September 10, 2022, indicated R15 received medication administration four times daily, behavior monitoring three times daily, vital sign monitoring, assist with dressing, toileting, transfers, bathing, laundry, bed making	01640		

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01640	Continued From page 36 and daily room order. On October 31, 2022, at 3:05 p.m., during a facility tour with RN-C and review of medication cart 1, the surveyor observed 5 syringes of as needed (prn) morphine 20 milligrams (mg)/milliliter (ml) 2.5 mg (0.125 ml) for R15. On October 31, 2022, directly following the above observation, the surveyor requested R15's medication set up documentation and later reviewed R15's medication set up documentation with RN-C On November 2, 2022, at 9:19 a.m., RN-C confirmed R15's service plan had not been revised to include medication setup. RN-C was not aware it was necessary to update R15's service plan. The licensee's undated Service Plan policy indicated service plans would be revised, if needed, based on resident reassessments and monitoring. Service plans and any revisions or updates would be entered into the resident's record, including notice of change in fees when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the	01710		

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01710	Continued From page 37 resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for four of four residents (R5, R3, R2, R4) who received medication management 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: During the entrance conference on October 31, 2022, at approximately 2:10 p.m., RN-C stated the licensee provided medication management services to the residents at the facility. R5 R5's diagnoses included hypertension (HTN-high blood pressure), chronic kidney disease (mild to moderate damage, kidneys are less able to filter waste and fluid out of blood), osteoarthritis of hands, depression, edema (swelling), and carpal tunnel syndrome (pressure on median nerve). R5's service plan dated October 25, 2022, indicated the resident received services which	01710		

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01710	Continued From page 38 included medication administration three times a day. R5's prescriber orders dated July 8, 2022, July 19, 2022, July 26, 2022, August 16, 2022, and October 6, 2022, included one thyroid medication, one vitamin, one bowel medication, and one pain medication. On November 1, 2022, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-H administer R5's scheduled morning medications. R3 R3's diagnoses included Alzheimer dementia with paranoia, HTN, diabetes, depression, delirium (serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings), and atrial fibrillation (irregular often fast heartrate). R3's service plan dated July 29, 2021, indicated R3 received services which included medication administration four times daily and weekly medication setup. R3's prescriber orders dated July 14, 2022, and October 26, 2022, included three antihypertensive medication, two anticonvulsant medication given for impaired cognition, two antidepressant, one antipsychotic, one blood thinner, one long-acting insulin, one laxative, and one supplement. On November 1, 2022, at 7:40 a.m., the surveyor observed ULP-D to administer R3's scheduled morning medications. R2 R2's diagnoses included dementia, sleep apnea (a serious sleep disorder that occurs when a	01710		

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01710	Continued From page 39 person's breathing is interrupted during sleep), depression, prostate cancer, and HTN. R2's service plan dated August 9, 2022, indicated R2 received services which included medication administration four times daily. R2's prescriber orders dated July 6, 2022, and October 28, 2022, included a mild pain reliever, one antianxiety medication, one antidepressant, one anticonvulsant given for impaired cognition, one antipsychotic, one patch for pain, one sleep aide, one multivitamin, two nasal sprays for dryness, and one medication to treat prostate cancer. On November 1, 2022, at 8:25 a.m., the surveyor observed ULP-D to administer R2's scheduled morning medications. R4 R4's diagnoses included history of sepsis (body's extreme response to an infection, life threatening medical emergency when an infection triggers a chain reaction throughout the body), benign prostate hypertrophy (BPN-enlarged prostate), gout (a form of inflammatory arthritis characterized by recurrent attacks caused by disposition of urate crystals), dermatitis, gastroesophageal reflux disease (GERD- where stomach content persistently and regularly flows up into the esophagus) and weakness. R4's service plan dated September 12, 2022, indicated R4 received services which included medication administration six times daily. R4's prescriber orders dated September 20, 2022, included three antihypertensive medications, one antidepressant, one pain	01710		

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01710	Continued From page 40 medication, two antidepressants, one blood thinner, one antipsychotic for behaviors, one anti-seizure/nerve pain medication for behaviors, two bowel medications, three supplements, eye medication for dry eyes, and one topical medication for itching. On November 1, 2022, at 9:04 a.m., the surveyor observed ULP-H administer R4's scheduled morning medications. R5, R3, R2 and R4's records lacked evidence the RN conducted a review of all medications the residents were known to be taking to include a review of the side effects and contraindications. On November 1, 2022, at 3:10 p.m., RN-C stated R5, R3, R2 and R4's medication reassessments did not include a review of each medications side effects or contraindications. RN-C stated this would be the same for all residents. The licensee's undated Medication Management policy noted the licensee would, prior to providing medication management services, have a RN, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services would be provided and how the services would be provided. The assessment would include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01710		

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01710	Continued From page 41 days	01710		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of four residents (R5). 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:	01760		

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01760	Continued From page 42 R5's diagnoses included hypertension (HTN-high blood pressure), chronic kidney disease (CKD-mild to moderate damage, kidneys are less able to filter waste and fluid out of blood), osteoarthritis of hands, depression, edema (swelling), and carpal tunnel syndrome (pressure on median nerve). R5's Service Plan dated October 25, 2022, indicated the resident received services which included medication administration three times a day. R5's Assessment dated October 18, 2022, indicated registered nurse (RN)/licensed practical nurse (LPN) to receive and process orders from physician. On November 1, 2022, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)- H remove R5's morning medication from a locked medication cart positioned in a hallway. ULP-H took the medications to R5's room and administered the medications to R5. R5's prescriber orders dated August 16, 2022, included "Buspar 5 milligrams (mg), by mouth (po), twice a daily (bid), diagnosis: anxiety, if family is dr [sic] with this". R5's Resident Notes entry dated August 16, 2022, included, "To start on Buspar (anxiety) 5 mg twice daily. Writer called and informed resident's daughter. [Name] would like to research medication prior to starting on the Buspar. Writer called and informed pharmacy to wait on filling medication until [daughter] calls to give permission to start on medication. Will await for [daughter] to ball back. Medication administration record (MAR) updated."	01760		

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01760	Continued From page 43 On November 2, 2022, at 9:40 a.m., RN-C stated the Buspar had not been started, the prescriber had not been notified, the order had not been discontinued. RN-C stated the family had not got back to nursing, adding, "missed that one [medication order]" The licensee's undated Medication & Treatment Orders policy indicated medication and treatment/therapy orders received facility must be implemented within 24 hours of receipt. An RN, LPN, therapist, or person at facility would was qualified to receive orders would obtain all medications and treatment orders either in writing or electronically by an authorized prescriber. The RN was responsible for assuring that: -current, authorized prescriber orders for medications or treatments administered by the staff were kept on file in the resident' record; -communicated to the resident or responsible party; -educated resident or responsible party on all medication and treatment orders; and -changes in orders are addressed in the resident's service plan and are communicated to the other staff. In addition, the licensed nurse would communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01770	Continued From page 44	01770		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R15, 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) 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 October 31, 2022, at approximately 2:10 p.m., registered nurse (RN)-C stated the licensee provided medication management services to include medication setup. R15 R15's diagnoses included Alzheimer's dementia. R15's service plan September 10, 2022, indicated R15 received medication administration four times daily. R15's service plan did not include	01770		

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01770	Continued From page 45 medication set up. R15's prescriber orders dated September 14, 2022, included an order for: - morphine (moderate to severe pain) 20 milligrams (mg)/milliliter (ml) 2.5 mg (0.125 ml) by mouth (po)/sublingual (sl-under tongue) every four hours for pain, scheduled; - morphine (20 mg/ml) 2.5 mg (0.125 ml) po/sl every two hours as needed (prn); and - lorazepam (anxiety) (2 mg/ml) 0.5 mg (0.25 ml) po/sl every three hours prn. On October 31, 2022, at 3:05 p.m., during a facility tour with RN-C and review of medication cart 1, the surveyor observed 5 syringes of prn 2.5 mg/ 0.125 ml morphine for R15. R15's Syringe Count Sheet for morphine 0.125 mg included staff signing out medication/syringe, date, time, amount on hand, amount given and amount remaining. The form included the date the medication was "filled." The first date on the form was September 14, 2022; the last date on the form was October 29, 2022. R15's syringe count sheet for "Ativan" (lorazepam) 0.25 mg, included: staff signing out medication/syringe, date, time, amount on hand, amount given and amount remaining. This form indicated 10 syringes were filled on September 12, 2022. One syringe was given on September 12, 2022, and one syringe was given on October 16, 2022, with 8 syringes remaining. R15's record lacked medication setup at the time of setup to include the: times to be administered, and route of administration. R3	01770		

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01770	Continued From page 46 R3's diagnoses included Alzheimer dementia with paranoia, hypertension (HTN-high blood pressure), diabetes, depression, delirium (serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings), and atrial fibrillation (irregular often fast heartrate). R3's service plan dated July 29, 2021, indicated R3 received services which included medication administration four times daily and weekly medication setup. R3's prescriber orders dated July 14, 2022, included an order for gabapentin 2 ml [equivalent to 100 milligrams] (an anticonvulsant medication given for impaired cognition) to be administered orally three times daily. On November 1, 2022, at 7:40 a.m., unlicensed personnel (ULP)-D was observed to administer R3's scheduled gabapentin medication. ULP-D obtained a prefilled syringe of gabapentin 2 ml [equivalent to 100 milligrams] from the medication refrigerator. ULP-D stated RN-G setup R3's prefilled gabapentin syringes. R3's gabapentin Pill Counting note in Rtasks [electronic documentation system] dated October 13, 2022, and written by RN-G noted "20 2 ml syringes filled". R3's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, quantity of dose, times to be administered, and route of administration. On November 1, 2022, at 1:32 p.m., RN-G stated they used to document medication setup on the narcotic log sheets but were recently told to	01770		

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01770	Continued From page 47 document medication setup in Rtasks. RN-G stated medication setup for R3's gabapentin did not include the required content noted above. On November 2, 2022, at 3:03 p.m., RN-C confirmed R15's record failed to include the time medication was to be administered, and the route of the medication. RN-C stated this information would be missing for all setup medication, "we do it [medication setup] the same way." The licensee's undated Medication Management policy noted for medications that cannot be setup in a dosage box (topical or liquid) will be recorded on the medication administration record (MAR) to include medication name, quantity of dose, times to be administered, route of administration, visual description of medication, and drug classification and special precautions. The licensed nurse will setup medications weekly and the setup will be documented on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the	01790		

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01790	Continued From page 48 medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;	01790		

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01790	Continued From page 49 (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-B) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. 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 November 2, 2022, at 12:34 p.m., registered nurse (RN)-C stated when the licensed nurse is not available, the ULP who have been medication pass trained can prepare and give medications to residents for unplanned times away. ULP-B was hired on July 7, 2021, to provide direct care for the licensee's residents which included medication administration.	01790		

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01790	Continued From page 50 ULP-B's employee record did not include evidence to indicate she had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. On November 2, 2022, at 2:04 p.m., RN-C stated ULP-B had not been trained or competency tested for preparing and providing medications to residents for unplanned times away. The licensee's Unplanned Time Away Medication Management Competency Checklist dated January 5, 2022, noted for unplanned time away, when a pharmacy is unable to provide the medications, a licensed nurse or properly trained and competency tested ULP may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven (7) calendar days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced	01890		

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01890	Continued From page 51 by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expiration date for six of six residents (R6, R7, R8, R16, R3, R10) and failed to ensure all medication included the original prescription label to include whom the medications was to be administered for two of two residents (R16, R3). In addition, the licensee failed to monitor for expired medications for three of three residents (R5, R13, and 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) 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: ASSISTED LIVING UNIT: TIME SENSITIVE MEDICATIONS/ ORIGINAL PRESCRIPTION LABEL On October 31, 2022, at 2:55 p.m., the surveyor observed two medication carts located in the assisted living unit with registered nurse (RN)-C. RN-C confirmed the following: -R6's opened latanoprost 0.005% (eye pressure) eye solution lacked a label to indicate the date the eye drop solution was opened and when the solution would expire; -R7's Advair Diskus (difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by asthma) 250	01890		

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01890	Continued From page 52 micrograms (mcg)/50 milligrams (mg), lacked a date the inhaler was removed from the foil package and when the inhaler would expire; -R8's opened Refresh Tears (lubricating eye drops) lacked a label to indicate the date the eye drop solution was opened and when the solution would expire; and -R16's Advair Diskus 250 mcg/50 mg, lacked a date the inhaler was removed from the foil package and when the inhaler would expire, and failed to include 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. EXPIRED MEDICATION -R5's levothyroxine (thyroid) 50 mcg had expired September 20, 2022; and -R13's polyvinyl alcohol (type of lubricant eye drop with helps provide dry eye relief) eye drop had expired on June 10, 2022. On October 31, 2022, at approximately 3:05 p.m., RN-C removed the expired medications from the medication from the assisted living medication cart. MEMORY CARE UNIT: TIME SENSITIVE MEDICATIONS/ ORIGINAL PRESCRIPTION LABEL On October 31, 2022, at 3:25 p.m., the surveyor observed one medication cart located in the memory care unit of the assisted living with RN-C. RN-C confirmed the following:	01890		

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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
01890	Continued From page 53 -R3's opened Muro 128 5% ophthalmic (eye) drops (reduce swelling of the surface of the eye) lacked a date the eye drops were opened and when the eye drops would expire; -R3's opened Ozempic 1 mg (to improve blood sugar) lacked a date the medication was opened and when the medication would expire, and failed to include 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;. and -R10's opened ketotifen fumarate 0.28% (prevent and treat itching eyes caused by allergies) lacked a label to indicate the date the eye drop solution was opened and when the solution would expire. EXPIRED MEDICATION -R2's Ultram (pain management) 50 mg had expired on October 21, 2022. On October 31, 2022, at approximately 3:30 p.m., RN-C removed the expired medications from the medication from the memory care medication cart. The manufacturer's instructions for the use of latanoprost eye drop solution dated June 2014, directed for the eye drop solution to be discarded six weeks after it had been opened. The manufacturer's instructions for Advair Diskus dated 2019, directed to discard 30 days after removal from foil pouch. The manufacturer's instructions for Refresh Tears dated March 2018, directed to discard the eye	01890		

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01890	Continued From page 54 drop solution 90 days after opening. The manufacturer's instructions for Muro 128 5% drops dated March 31, 2022, directed once opened the product must be used within 30 days. The manufacturer's instructions for Ozempic dated July 7, 2022, directed to either store pen for 56 days at room temperature (between 59 degrees Fahrenheit (F) to 86 degrees F) or you can still keep it in the refrigerator for 56 days. The manufacturer's instructions for ketotifen fumarate dated February 2022, directed once opened, the eye drops can be used for up to 15 days. The licensee's undated Medication Storage policy indicted medications would be stored per manufacturer's directions. 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:	01940		

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01940	Continued From page 55 (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 registered nurse (RN) failed to specify, in writing, specific instructions for catheter (tube placed in the body to drain and collect urine from the bladder) care for one of one resident (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 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).	01940		

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01940	Continued From page 56 The findings include: During the entrance conference on October 31, 2022, at 2:30 p.m., RN-C confirmed the licensee provided treatment and therapy services to residents as prescribed. R4's diagnoses included history of sepsis (body's extreme response to an infection, life threatening medical emergency, when an infection triggers a chain reaction through the body), benign prostate hypertrophy (BPN-enlarged prostate), gout (a form of inflammatory arthritis characterized by recurrent attacks caused by disposition of urate crystals), dermatitis, gastroesophageal reflux disease (GERD- where stomach content persistently and regularly flows up into the esophagus) and weakness. R4's service plan dated September 12, 2022, indicated R4 received services which included catheter care five times per day. R4's nursing assessment dated October 31, 2022, included staff to check and empty catheter. Staff to change resident to night bag at night and day bag, during the day. Staff to ensure to complete catheter cleaning twice a day and as needed. R4's prescriber orders dated September 20, 2022, included: Catheter Care -cleanse surrounding area and tubing to suprapubic cath twice daily; -empty bag, change to leg bag, observe skin and document color of urine, odor, amount and if sediment present; and -notify RN if there are any signs/symptoms of catheter not fitting properly, discoloration/alteration of skin, blockage of	01940		

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01940	Continued From page 57 drainage tube or pain with placement of catheter. On November 1, 2022, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-H administer R5's scheduled morning medications. R4's record lacked evidence the RN specified, in writing, specific instructions for cleaning the catheter bags. On November 2, 2022, at 12:05 p.m., RN-C confirmed R4's record lacked to include written instructions for cleaning R4's catheter bags (night/day). The licensee's undated Delegation of Assisted Living Services policy indicated the RN would include specify, in writing, specific instructions for each resident and document those instructions in the resident's record and communicate with the unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02110 SS=D	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy	02110		

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02110	Continued From page 58 shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required dementia care policies and procedures were provided to one of two residents (R3) and/or the resident's legal and designated representative. 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	02110		

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02110	Continued From page 59 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee held an assisted living with dementia care license and was licensed for a capacity of 62 residents. R3's diagnoses included Alzheimer dementia with paranoia, hypertension (HTN-high blood pressure), diabetes, depression, delirium (serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings), and atrial fibrillation (irregular often fast heartrate). R3 resided in the facilities secure memory care unit and received services under the licensee's assisted living with dementia care license. R3's record did not include evidence or documentation the resident or resident's representative had received the policies and procedures related to dementia care as required. On November 2, 2022, at 9:52 a.m., registered nurse (RN)-C stated the dementia care policies had not been provided to R3 or R3's representative. RN-C stated she thought everyone had signed that they had received them, but they must have missed R3. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		

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02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the treatment administration process was followed for one of four employees, unlicensed personnel (ULP)-I. 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 November 1, 2022, at 7:47 a.m., the surveyor observed unlicensed personnel (ULP)-I remove a blood glucose meter (device used to monitor blood sugar levels), blood glucose (BG) testing strip, lancet (small needle used to poke the skin [usually on a finger] to get a small drop of blood), and a sharps container (sharps/needle disposal container) out of a cabinet in R14's kitchen. ULP-I took the above-mentioned supplies and placed	02320		

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02320	Continued From page 61 them on a table near R14. With gloved hands ULP-I asked R14 if she had a preference on which finger would be used for BG testing. R14 put out her left hand and ULP-I placed a lancet on R14's middle finger on her left hand. ULP-I wiped the first drop of blood away and used the second drop for BG testing. The surveyor did not observe ULP-I clean R14's finger prior to BS testing. On November 1, 2022, directly following the above observation ULP-I confirmed she had not cleaned R14's finger before using the lancet, ULP-I stated she normally cleans the resident's finger prior to BG testing. On November 1, 2022, at 11:42 a.m., RN-C stated R14's finger should have been cleaned with an alcohol wipe prior to ULP-I using a lancet to obtain a BG reading. The licensee's undated Delegation of Assisted Living Services policy indicated the RN may delegate nursing services to a person who had successfully completed staff orientation, who had been trained in the service to be provided, and who had demonstrated to the RN the ability to competently follow the procedures for the resident. Performing routine delegated medical or nursing procedures, such as: glucometers, compression stocking (TEDs), Foley catheter (thin flexible tube placed in bladder to drain urine), oxygen administration, and dressing changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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02410	Continued From page 62	02410		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two resident's (R2, R12) privacy was respected with regards to electronic monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	02410		

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02410	Continued From page 63 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: R2 R2's diagnoses included dementia, sleep apnea (a serious sleep disorder that occurs when a person's breathing is interrupted during sleep), depression, prostate cancer, and hypertension (HTN-high blood pressure). R2's service plan dated August 9, 2022, indicated R2 received services to include medication administration, and assistance with dressing, hygiene, showering, transferring and toileting. R2's Assessment dated September 9, 2022, indicated R2 required assistance with incontinence care. R2 is pleasantly confused and has cognitive impairment related to progression with dementia diagnoses. R12 R12's diagnoses included dementia without behavioral disturbances, Parkinson's disease (a chronic progressive neurological disease which exhibits symptoms such as tremors, rigidity, impaired balance, slowness of movement and shuffling gait), anxiety, and generalized weakness. R12's service plan dated August 17, 2022, indicated R12 received services to include medication administration, assistance with dressing, hygiene, grooming, toileting, transferring and showering.	02410		

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02410	Continued From page 64 R12's Assessment dated October 21, 2022, indicated R12 requested only female caregivers to assist with dressing and grooming. R12 can become agitated and paranoid during episodes of hallucinations. R12 had a video monitor placed in the resident's room on January 5, 2022, as a fall intervention. On October 31, 2022, at 3:45 p.m., the surveyor toured the memory care unit with executive director (ED)-A. The surveyor observed on a small stand located in the entrance hallway and adjacent to the medication cart were two electronic video monitors (with a screen size of approximately seven inches by five inches). The screens of the monitors were facing towards the open hallway and could be visualized by any staff, visitor, or resident in the area. Both monitors were turned on and R12 was observed to be lying in her bed. On October 31, 2022, at 3:53 p.m., ED-A stated the monitors were for R2 and R12. Both monitors had audio and live feed video capability. ED-A stated the live feed could not be accessed on any other electronic device other than the monitor. ED-A stated the monitors had been placed in the resident's rooms as they were both a fall risk. ED-A stated the monitors were in a public area. On November 1, 2022, at 7:38 a.m., the surveyor observed R2 and R12's electronic monitors to be on and remained located on the small stand in the entrance hallway and adjacent to the medication cart in the memory care unit. Both monitors were visible to any visitors, staff or residents in the area. R12 was observed to be lying in her bed. At 8:43 a.m., the surveyor observed, via R12's electronic monitor, unlicensed personnel (ULP)-B to transfer R12 out	02410		

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02410	Continued From page 65 of her bed and into her wheelchair. At 8:53 a.m., the surveyor observed, via R12's electronic monitor, ULP-B to transfer R12 from her wheelchair to a recliner in the resident's room. R12 remained in full view of the camera. On November 1, 2022, at 9:43 a.m., the surveyor observed, via R2's electronic monitor, R2 lying in bed. ULP-F lowered R2's pants and checked R2's brief. ULP-F then pulled R2's pants back up and covered the resident up leaving R2 in bed and in full view of the camera. On November 1, 2022, at 9:55 a.m., registered nurse (RN)-C and RN-G stated the placement of R2 and R12's electronic video monitors were not in a private area and could be visualized by any visitor, staff or resident who may walk down the main entrance hallway of the memory care unit. RN-G stated these were the only residents who had electronic monitoring devices. The licensee's Resident Dignity policy dated July 2022, noted the licensee would strive to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and individuality. Maintaining a resident's dignity should include assistance with personal care provided in a private and respecting the resident's private space and property. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		
03070 SS=D	144.6502, Subd. 6 Form Requirements	03070		

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03070	Continued From page 66 Subd. 6.Form requirements. (b) Facilities must make the notification and consent form available to the residents and inform residents of their option to conduct electronic monitoring of their rooms or private living unit. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain consent for electronic monitoring for one of two residents (R12) who had an electronic monitor device in place. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R12's diagnoses included dementia without behavioral disturbances, Parkinson's disease (a chronic progressive neurological disease which exhibits symptoms such as tremors, rigidity, impaired balance, slowness of movement and shuffling gait), anxiety, and generalized weakness. R12's service plan dated August 17, 2022, indicated R12 received services to include medication administration, assistance with dressing, hygiene, grooming, toileting, transferring and showering.	03070		

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EDGEWOOD ALEX SENIOR LIVING	1902 7TH AVENUE EAST ALEXANDRIA, MN 56308

(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
03070	Continued From page 67 R12's Assessment dated October 21, 2022, indicated R12 had a video monitor placed in the resident's room on January 5, 2022, as a fall intervention per verbal consent from R12's daughter. R12's record lacked a written consent for the electronic monitoring device that was placed in R12's room. On November 2, 2022, at 3:50 p.m., registered nurse (RN)-C stated the licensee's policy had not been followed as R12 did not have the appropriate signed consent form for electronic monitoring. RN-C stated they must have forgotten to follow up with getting the written consent form signed after obtaining the verbal consent from R12's daughter. The licensee's Electronic Monitoring - MN (Minnesota) policy dated June 2022, noted prior to conducting electronic monitoring, a resident, or their resident representative must consent to electronic monitoring in writing on the notification and consent form developed by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03070		

Minnesota Department of Health

PO Box 64495
St Paul, Minnesota
651-201-4500

Type: Full
Date: *11/01/22*
Time: 10:30:56
Report: 1008221051

Food and Beverage Establishment Inspection Report

Location:
Edgewood Alex Senior Living
1902 7th Avenue East
Alexandria, MN56308
Douglas County, 21

Establishment Info:
ID #: 0037927
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207592121
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.

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

3-304.12A

MN Rule 4626.0275A Store food preparation or dispensing utensils in the food with the handles above the top of the food within the container.

SCOOPS WERE LAYING FLAT ON TOP OF THE FOOD IN THE BULK FOOD CONTAINERS (FLOUR, SUGAR). IF SCOOPS ARE HELD WITHIN BULK FOOD STORAGE CONTAINERS THE HANDLED SHALL BE ABOVE THE TOP OF THE FOOD WITHIN THE CONTAINER.

Comply By: 11/01/22

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

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

THE SANITIZING SOLUTION IN THE SANITIZING BUCKET WAS AT 0 ppm. THE BUCKET WAS DUMPED AND REFILLED WITH ECO LAB MIXING SYSTEM ON BACK OF 3 COMPARTMENT SINK. RETEST AND USED ON SITE TEST STRIPS STILL 0 ppm. CONTINUED IN GENERAL COMMENTS.

Comply By: 11/01/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

MOP IN THE SERVICE KITCHEN WAS CURRENTLY STORED WITHIN THE EMPTY MOP BUCKET. HANG MOPS TO ALLOW FOR PROPER DRYING.

Type: Full
Date: *11/01/22*
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Edgewood Alex Senior Living

Food and Beverage Establishment Inspection Report

Comply By: 11/01/22

Surface and Equipment Sanitizers

Chlorine: = 50 at Degrees Fahrenheit
Location: Dish machine main kitchen
Violation Issued: No

Chlorine: = 0 at Degrees Fahrenheit
Location: Sanitizer bucket
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Upright Cooler - Single Do
Temperature: 41 Degrees Fahrenheit - Location: Dressing - main kitchen
Violation Issued: No

Process/Item: Upright Cooler - 3 Door
Temperature: 36 Degrees Fahrenheit - Location: Lunch meat - main kitchen
Violation Issued: No

Process/Item: Cooking
Temperature: 198 Degrees Fahrenheit - Location: Broccoli cheese soup
Violation Issued: No

Process/Item: Cooking
Temperature: 178 Degrees Fahrenheit - Location: Salmon
Violation Issued: No

Process/Item: Upright Cooler - 2 Door
Temperature: 37 Degrees Fahrenheit - Location: milk - service kitchen
Violation Issued: No

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

CONTINUED: MN RULE 4626.0285B - USE OF SANITIZER BUCKET WILL BE DISCONTINUED UNTIL BLEACH IS OBTAINED OR THE MIXING FAUCET IS FIXED. THERE WAS A DISCUSSION OF HOW TO MIX UP AN APPROVED CONCENTRATION USING BLEACH AND WATER.

THINGS TO REMEMBER:

1 THE CERTIFIED FOOD PROTECTION MANAGER SHOULD BE ROUTINELY CONDUCTING SELF INSPECTIONS TO ENSURE THAT EMPLOYEES ARE FOLLOWING PROPER FOOD HANDLING PRACTICE.

2 EDUCATE EMPLOYEES ON THE IMPORTANCE OF REPORTING TO MANAGEMENT ANY ILLNESS THEY HAVE OR HAVE HAD RECENTLY. MANAGEMENT SHOULD EXCLUDE ANY WORKERS ILL WITH VOMITING OR DIARRHEA FROM HANDLING FOOD, AND THEY SHOULD KEEP AN UP TO DATE EMPLOYEE ILLNESS LOG.

3 THERE SHOULD BE A PERSON IN CHARGE A THE ESTABLISHMENT DURING ALL HOURS

OF OPERATION. THIS PERSON SHOULD ENSURE THAT EMPLOYEES ARE PRACTICING GOOD HAND WASHING PROCEDURES, INCLUDING BEING KNOWLEDGEABLE ABOUT WHEN HAND WASHING SHOULD BE DONE AND HOW TO PROPERLY WASH HANDS.

4. EMPLOYEES SHOULD USE SPATULA, TONGS, DELI TISSUE, GLOVES OR SOME OTHER APPROVED MEANS TO PREVENT ANY DIRECT BARE HAND CONTACT WITH READY TO EAT FOODS.

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 1008221051 of 11/01/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed: emailed to HRD
Establishment Representative

Signed: Inspector ID# 1008
Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us