



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 14, 2023

Licensee
Silvercrest Properties LLC
2700 Rice Creek Road
New Brighton, MN 55112

RE: Project Number(s) SL20231015

Dear Licensee:

On August 9, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 20, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jess Schoenecker'.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 24, 2023

Licensee
Silvercrest Properties LLC
2700 Rice Creek Road
New Brighton, MN 55112

RE: Project Number(s) SL20231015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 23, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

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

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

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20231	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2023
NAME OF PROVIDER OR SUPPLIER SILVERCREST PROPERTIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 RICE CREEK ROAD NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20231015 On June 20, 2023, through June 23, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 75 active residents; all receiving services under the Assisted Living with Dementia Care license. Immediacy of order 1750 was removed on June 23, 2023, based on supervisor review. The scope and level remain the same.	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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the daily staffing schedule was posted in a central location in the facility, accessible to staff, residents, volunteers, and the public as required, potentially affecting the licensee's current residents, staff, and any visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care license. The facility was licensed for a bed capacity of 86 residents and had a current census of 75 residents. During a tour of the facility with licensed assisted living director (LALD)-D on June 20, 2023, at 11:20 a.m., the surveyors observed the facility layout included entrance to the facility, a large common area, and unsecured assisted living resident apartments on the first (main) floor, unsecured assisted living resident apartments on the second and third floors, and secured memory care units were also located on the second and third floor. The surveyors observed a Nursing Hours Posting dated June 20, 2023, posted behind the receptionist's counter, on the wall beside the receptionist, only visible to the receptionist, and the same document posted outside the nursing office on the second floor. In each secured memory care unit, a whiteboard included the staff currently working; however, on June 21, 2023, at 5:30 p.m., the whiteboard in the secured memory care unit on the second floor, listed the names of the staff that had worked from 6:00 a.m. to 2:30 p.m. that day, not the current staff working. The licensee lacked a posted daily staffing schedule in a central location, accessible to all staff, residents, volunteers, and visitors to the facility.	0 470			

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0 470	Continued From page 3 On June 20, 2023, at 11:38 a.m., LALD-D indicated the daily staffing schedule was not posted in a central location, accessible to staff, residents, volunteers, and visitors to the facility. The licensee's 4.06 Staffing & Scheduling policy dated September 9, 2022, indicated the daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift, in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) 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: (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	0 480			

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0 480	Continued From page 4 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 20, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of one employee (unlicensed personnel (ULP)-N) observed to complete blood glucose testing and	0 510			

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0 510	Continued From page 5 insulin administration. 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 June 21, 2023, at 4:10 p.m., the surveyor observed while ULP-N prepared to conduct R3's blood glucose testing. ULP-N gathered needed supplies from a large, locked box in R3's closet. ULP-N donned (applied) gloves, used an alcohol pad to clean R3's finger, and poked the finger with a lancet (needle). ULP-N was unable to obtain a drop of blood from R3's finger, tossed the lancet into the trash rather than in the sharps container on the table, obtained a new lancet, and repeated the process. ULP-N was able to obtain a drop of blood, placed the blood on the strip in the glucose monitor, and stated the results were "219." ULP-N threw the lancet into the sharps container on the table, doffed (removed) the gloves, performed hand hygiene with hand sanitizer, documented the results on the tablet, and stated she would wait to give R3's insulin until she talked to the nurse. At 4:58 p.m., licensed practical nurse (LPN)-G arrived on the unit and ULP-N asked if she should give the insulin. LPN-G directed ULP-N to give the insulin as ordered. R3's diagnoses included dementia, Alzheimer's disease, and diabetes.	0 510			

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0 510	Continued From page 6 R3's Service Plan (Private) - Addendum to Contract dated May 3, 2023, indicated R3 received services including assistance with bathing, dressing, nail care, behavior monitoring, safety checks, toileting, transferring, medication administration, and blood glucose monitoring twice daily. R3's prescriber orders signed May 2, 2023, included Lantus (long acting insulin) Solostar injection 100 units/milliliter subcutaneous (under the skin), "as needed" at 5:00 p.m.; however, directions included, "Prime pen with 2 units; Inject 8 u [units] subcutaneously daily (dx: [diagnosis] diabetes mellitus). Alternate site." On June 21, 2023, at 5:10 p.m., ULP-N washed her hands and donned gloves, and prepared to give R3's insulin. ULP-N uncapped the insulin pen, and without cleaning the pen tip (rubber seal) with an alcohol pad, ULP-N screwed on the disposable needle. Then, without priming the insulin pen, ULP-N dialed the insulin pen to 8 units, exposed R3's abdomen, cleaned the area with an alcohol pad, and administered the insulin. On June 21, 2023, at 5:23 p.m., ULP-N stated she recalled being trained to give insulin by a nurse, and stated she remembered being instructed to clean the pen tip before placing the disposable needle, priming the needle prior to dialing the ordered dosage, and throwing the lancet into the sharps container rather than into the trash. ULP-N stated, "I'm kind of a little nervous." On June 22, 2023, at 2:50 p.m., interim clinical nurse supervisor (CNS)-A stated ULP-N had attended new employee orientation; however,	0 510			

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0 510	Continued From page 7 stated she had scheduled ULP-N for medication administration reeducation next week. The licensee's 7.36 Insulin policy dated August 1, 2021, indicated insulin must be administered according to the prescribers' orders and need to be administered according to the "6 Rights" including right person, right medication, right time, right route, right dose, and right record to document that the medication was taken; however, lacked the procedure when giving insulin. The licensee's 8.01 Infection Control Policy dated August 1, 2021, indicated the licensee would identify areas where infection control practices were necessary based on the exposure and risk of the facility, and the infection control program would be consistent with current guidelines from the Centers for Disease Control and Prevention (CDC) for prevention control in long-term care facilities, where applicable in assisted living facilities. The Sanofi (manufacturer) Lantus Solostar Pen Guide, dated August 2022, directed to remove the pen cap with clean hands and to wipe the pen tip (rubber seal) with an alcohol swab before screwing on the needle. Also, the guide directed to place used needles in sharps container or use a strong plastic bottle that cannot be punctured when disposing of the needle. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			

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0 570	Continued From page 8	0 570			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance of the assisted living facility. This had the potential to affect all 75 current residents, staff, and visitors. 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 the residents). The findings include: On June 20, 2023, at 10:00 a.m., upon entering the facility, the surveyor did not observe the license posted at the facility main entrance, as required. On June 20, 2023, at 11:20 a.m., during a facility tour with licensed assistant living director (LALD)-D, the surveyor observed the license hanging on the back wall of the enclosed receptionist desk area. The license was not clearly visible by visitors or residents. During an interview on June 22, 2023, corporate regional director (RD)-I stated the license was not	0 570			

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0 570	Continued From page 9 visible to visitors or residents in its current location and stated she would move the license to a location near the main entrance of the facility. The licensee's 2.04 Assisted Living License and Posting policy dated August 1, 2021, indicated a current Assisted Living License issued by the Minnesota Department of Health would be displayed at the main entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of eight residents (R4, R11).	0 630		

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0 630	Continued From page 10 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: R4 R4's diagnoses included Alzheimer's Disease. R4's Service Plan dated May 10, 2023, indicated R4 received services including bathing, bed mobility, behavior monitoring, compression stockings, medication administration, dressing, modified diet, toileting, and wound care. R4's Assessment As Of Date dated April 5, 2023, identified as "90 Day" assessment, included areas of vulnerabilities to herself and the resident's susceptibility to abuse by another individual, including other vulnerable adults with measures to minimize the risk; however, R4's assessment lacked an individualized review or assessment of the resident's risk of abusing other vulnerable adults and potential risk of self-abuse. R11 R11's diagnoses included encephalopathy (disease of the brain). R11's Service Plan (Private) - Addendum to Contract signed May 25, 2023, indicated R11 received services including bed mobility, transfer assistance, dressing, toileting, oxygen assistance, and wound care. R11's Assessment As Of Date dated May 11,	0 630			

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0 630	Continued From page 11 2023, identified as "90 Day" assessment, lacked an individualized review or assessment of R11's risk of being abused by other individuals. On June 22, 2023, at 3:16 p.m., interim clinical nurse supervisor (CNS)-A stated R4's assessment did not specifically address R4's risk of abusing other vulnerable adults or risk of self-abuse, and stated she expected nurses to answer these questions on every single assessment so that the information populated on the electronic medical record. Additionally, CNS-A stated R11's assessment did not address R11's risk of being abused by other individuals. The licensee's 6.05 Individual Abuse Prevention Plan policy dated April 4, 2022, indicated the licensee would develop and implement an individual abuse prevention plan for each vulnerable adult and would contain an individualized review or assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults, the resident's risk of abusing other vulnerable adults, and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	0 650			

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0 650	Continued From page 12 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for three of three employees (unlicensed personnel (ULP)-B, ULP-L, ULP-N). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 650			

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0 650	Continued From page 13 ULP-B ULP-B was hired on August 1, 2021, to provide direct care services to residents of the facility. During observation on June 21, 2023, at 9:10 a.m., ULP-B and ULP-H assisted R11 with dressing then sat R11 at edge of bed and applied a transfer belt around the waist. ULP-B and ULP-H assisted R11 to standing position with two-wheel walker, then R11 took a few steps to turn and sit into the wheelchair. R11 was then transferred into the recliner in the living room. ULP-B's employee record included a training record labeled My Transcript printed June 21, 2023, which indicated ULP-B's completion of some training; however, lacked documentation of training and competency evaluations for the following: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -preparation of modified diets as ordered by a licensed health professional; -understanding appropriate boundaries between staff and residents and the resident's family; and -awareness of commonly used health technology	0 650			

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0 650	Continued From page 14 equipment and assistive devices; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required. On June 23, 2023, at 12:32 p.m., corporate regional director (RD)-I confirmed ULP-B attended day one of new employee orientation at another facility by ULP-B's timecard, and the rest of ULP-B's training was completed by the licensee on site. RD-I stated she was unable to locate documentation these competencies were completed. ULP-L ULP-L was hired on April 10, 2023, to provide direct care services to residents of the facility. On June 21, 2023, at 3:13 p.m., the surveyor observed ULP-L interacted with residents living on the memory care unit on the second floor of the facility. ULP-L stated she performed delegated services, including medication administration and catheter cares and stated she was trained during orientation by a nurse. ULP-L's employee record included [Licensee] New Employee Orientation - Resident Assistant, dated April 11, 2023, and April 12, 2023, which indicated ULP-L's completion of various trainings and skill assessments; however, lacked	0 650		

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0 650	Continued From page 15 documentation of training and competency evaluations for the following: - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting; and - awareness of commonly used health technology equipment and assistive devices; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On June 22, 2023, at 9:37 a.m., interim clinical nurse supervisor (CNS)-A stated new unlicensed employees attended two days of new employee orientation, including general orientation on the first day and Educare (online training modules) and skill assessments on the second day. CNS-A stated the above missing items were not included on ULP-L's documentation. ULP-N ULP-N had a start date of January 10, 2022. ULP-N's record lacked evidence of the following: - records of competency evaluations. On June 21, 2023, at 3:21 p.m., ULP-N stated she had worked at the facility for about 16 months and provided services, including medication administration for the licensee's residents living in the memory care unit. ULP-N stated she had classroom medication training upon hire, by the	0 650			

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0 650	Continued From page 16 nurse, and recalled being observed by the nurse while giving medications. At 4:22 p.m., the surveyor observed while ULP-N completed blood glucose testing and medication administration, including oral medications and insulin. On June 22, 2023, at 1:05 p.m., corporate regional director (RD)-I stated ULP-N's record indicated she had attended new employee orientation upon hire which included medication administration and competency assessment and provided evidence of ULP-N's timecard that indicated she attended the training; however, ULP-N's record lacked documentation of having completed competency evaluations. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated prior to the delegation of services, the registered nurse must make certain the ULP was trained in the proper methods to perform the tasks or procedures for each resident and were able demonstrate the ability to competently follow the procedures and perform the tasks. The policy directed training and competency evaluations for all ULPs would include: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting;	0 650			

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0 650	Continued From page 17 - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices.\; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records for each person would include records of all training and in-service education required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			

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0 800	Continued From page 18	0 800			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. 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 June 21, 2023, at approximately 10:00 a.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-D, Maintenance Technician (MT)-J, and Corporate Director of Environmental Services (DES)-K. During the facility tour, survey staff observed the following: In the beauty shop on the first floor, it was	0 800			

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0 800	Continued From page 19 observed that there was a considerable brown stain on the gypsum board ceiling with evidence of water damage. In the corridor on the first floor, it was observed that the ceiling light fixtures were hanging loose with missing trims. During the interview, MT-J stated that all ceiling fixtures would be replaced with the energy-efficiency fixture type. It was observed that several ceiling light fixtures on the second-floor corridor and the third-floor corridor were hanging loose with no trim also. In the dining room on the first floor, it was observed that the fire-rated door with magnetic hold open was propped open with a rubber door wedge. The door must positively latch to protect the occupants and to contain the spread of fire in case of fire, but the rubber wedge will prevent the door from closing. During the interview, MT-J stated that the door magnet did not hold the door open due to the magnetic attraction got weakened, and they used the rubber wedge to keep the door open. In the restroom by the dining room on the first floor, it was observed that the wall-mounted supply air grille was loose with missing screws. And also sprinkler head was spray painted. In resident unit 101, it was observed that the door closer to the resident door had been disabled by removing the closure arm or closure device. The door had a portion or remnants of the closure device still mounted on the door. MT-J stated that the facility removed the door closer and installed spring hinges instead. He also stated that this was consistent with many other resident units throughout the facility. Modifying a fire-rated door can affect the integrity of the door. Any	0 800			

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0 800	Continued From page 20 modifications should be in line with the manufacturer's guidelines and should be undertaken by a competent person. In the egress stair by resident unit 212 on the second floor, it was observed that the door frame bears a fire rating label, but the door did not have any fire rating information on it. During the interview, MT-J confirmed that both the door and door frame need to be rated assembly to maintain the fire barrier integrity of the egress stair. In resident unit 215 on the second floor, it was observed that the resident's unit door was sliding door with no fire rating information. During the interview, DES-K confirmed that the sliding door is not fire-rated, and the door has to be rated to maintain the fire barrier from the corridor. In resident unit 210 on the second floor, it was observed that the electrical outlet cover was missing in the sleeping room. In resident unit 220 on the second floor, it was observed that there was a considerable brown stain on the gypsum board ceiling with evidence of water damage. It was also observed that the radiant heater baseboard was missing cover plates and exposing sharp metal edges in the unit. In the Laundry door on the third floor, it was observed that the door was identified as a fire-rated door, but the door jamb installation was not sufficient to meet the rating requirement. There was an inch gap between the hollow metal jamb and gypsum board termination. A temporary wood block was inserted in the gap.	0 800			

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0 800	Continued From page 21 In resident unit 300 on the third floor, it was observed that the door frame bears a fire rating reconned label, but the door did not have any fire rating information. During the interview, MT-J confirmed that both the door and door frame need to be rated assembly to maintain the fire integrity of the resident room and corridor for safety purposes. During the facility tour interview, MT-J and DES-K visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	0 810			

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0 810	Continued From page 22 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements; failed to provide procedures necessary for resident movement, evacuation or relocation during a fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation; failed to provide required employee training on fire safety and evacuation and failed to conduct required evacuation drills as required. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 810		

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0 810	Continued From page 23 An interview and record review were conducted on June 21, 2023, at approximately 12:00 p.m., with Licensed Assisted Living Director (LALD)-D, Maintenance Technician (MT)-J, and Corporate Director of Environmental Services (DES)-K on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did not include the facility-specific procedures for resident movement evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During the interview, LALD-D verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that employees did not receive training twice per year after initial hire. During the interview, LALD-D stated that the licensee provided annual training to employees, but not twice per year after the initial hire, on the fire safety and evacuation plan, as required by statute. During the interview, LALD-D stated that the facility provided only one fire safety training on 7/26/22 and confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. Record review of the available documentation indicated that the licensee did not conduct	0 810			

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0 810	Continued From page 24 evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 3-19-23, 2-24-23, 2-21-23, 2-6-23, 7-26-22, and 1-17-22, with no further drills being documented. Further review of the available documentation indicated that the facility failed to provide two drills on the second shift and third shifts. LALD-D verified that there were no further drills conducted besides those that were provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	01060		

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01060	Continued From page 25 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for two of two residents (R1, R2) hospitalized. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1	01060		

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01060	Continued From page 26 R1 was admitted for services on July 28, 2017, with a diagnosis of hypertension (high blood pressure). The licensee's Discharged Resident/Client Roster printed on June 20, 2023, indicated R1 discharged on March 1, 2023, and relocated to higher level of care after hospitalization. R1's records lacked evidence of a written notice provided to the resident, that contained, at a minimum: - the contact information for the location to which the resident had been relocated and any new service provider; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. R2 R2 was admitted for services on February 22, 2021, with diagnoses including Alzheimer's Disease, high blood pressure, polymyalgia rheumatica (pain and stiffness in shoulders, neck, and hips), and history of skin and breast cancer. R2's Service Plan (Private) - Addendum to Contract printed June 20, 2023, indicated R2 received services including assistance with activities, bathing, bed mobility, behavior, dressing, grooming, medication administration, toileting, and safety checks. R2's Resident Notes-One Resident dated April 1, 2023, at 3:30 a.m., indicated R2 was found next to her bed on the floor in her bedroom at 2:21 a.m., and had a laceration to the scalp and was bleeding. R2 was transported to the hospital for	01060			

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01060	Continued From page 27 evaluation. R2 returned to the facility on April 2, 2023, at 1:30 p.m., with four staples to her scalp. R2's records lacked evidence of a written notice provided to the resident, that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. During an interview on June 20, 2023, at 3:06 p.m., interim clinical nurse supervisor (CNS)-A stated the emergency relocation form was missing the contact information for the hospital R1 relocated to and the right to appeal statement. CNS-A stated she would update the form and hopefully streamline the form for the licensee to use. During an interview on June 21, 2023, at 11:00 a.m., licensed assisted living director (LALD)-D stated she was aware of the notice required, but understood the notice was to be given if the resident was hospitalized more than four days. LALD-D stated there was no written notice for R2 that she could find. The licensee's 1.23 Emergency Relocation policy	01060		

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01060	Continued From page 28 dated August 1, 2021, indicated the facility may remove a resident from the facility in an emergency if necessary due to the resident's urgent medical needs or an imminent risk the resident posed to the health or safety of another facility resident or staff member, and in the event of an emergency relocation, would provide a written notice that contained the above required content. The notice would be delivered as soon as practicable to the resident, legal representative, and designated representative, and the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290			

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01290	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of five employees (registered nurse (RN)-C, unlicensed personnel (ULP)-L, ULP-M). 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: RN-C RN-C obtained her RN license on February 11, 1998. RN-C was hired by the licensee on August 1, 2022, to provide supervision of staff and direct care services to the residents. RN-C's employee record contained a background study, submitted by a licensee with a different Health Facility Identification Number (HFID), operated by the same corporation, dated December 16, 2022. RN-C's employee record lacked evidence the licensee submitted a background study for their license and current HFID number. ULP-L ULP-L started employment on April 10, 2023, to provide direct care assisted living services to the licensee's residents.	01290			

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01290	Continued From page 30 ULP-L's employee record contained a background study, submitted by a licensee with a different HFID, operated by the same corporation, dated March 14, 2023. ULP-L's employee record lacked evidence the licensee submitted a background study for their license and current HFID number. ULP-M ULP-M was hired on April 10, 2023, to provide direct care assisted living services to the licensee's residents. ULP-M's employee record contained a background study, submitted by a licensee with a different HFID, operated by the same corporation, dated March 28, 2023. ULP-M's employee record lacked evidence the licensee submitted a background study for their license and current HFID number. During an interview on June 21, 2023, at 1:02 p.m., corporate regional director (RD)-I stated the licensee's staff member responsible for submitting background studies is new to her position and when inputting information, she has been choosing the wrong entity. RD-I stated they would be working to correct this immediately. The licensee's 4.02 Background Studies policy effective December 14, 2022, directed all employees, contractors and all volunteers of the facility with direct resident contact would undergo a background study through the Department of Human Services (DHS) and once an approved background study had been received, staff would be allowed to interact or provide services to residents, assuming all other requirements had been met.	01290			

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01290	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted supervision of unlicensed staff as required for six of six employees (unlicensed personnel (ULP)-B, ULP-L, ULP-N,	01440			

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01440	Continued From page 32 ULP-O, ULP-P, ULP-Q) performing delegated services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B had a start date of August 1, 2021, to provide direct care services to residents of the facility. During observation on June 21, 2023, at 9:10 a.m., ULP-B assisted with transferring R11 from the bed to wheelchair then into a recliner in the living room. ULP-B stated she provided medication administration to the residents she was assigned to care for. ULP-B's Staff Supervision Summary dated August 1, 2021, through June 21, 2023, indicated a RN supervised ULP-B on November 11, 2021, or 101 days after hire, while giving a shower. ULP-B's record lacked evidence a RN conducted direct supervision of ULP-B within 30 days of performing delegated tasks, as required. ULP-L ULP-L was hired on April 10, 2023, to provide direct care services to residents of the facility. On June 21, 2023, at 3:13 p.m., the surveyor observed while ULP-L interacted with residents	01440			

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01440	Continued From page 33 living on the memory care unit on the second floor of the facility. ULP-L stated she performed delegated services, including medication administration and catheter cares and stated she was trained during orientation by a nurse. ULP-L's record lacked evidence a RN conducted direct supervision of ULP-L within 30 days of performing delegated tasks. ULP-N ULP-N had a start date of January 10, 2022, to provide direct care services to residents of the facility. On June 21, 2023, at 3:21 p.m., ULP-N stated she had worked at the facility for about 16 months and provided delegated services, including medication administration. At 4:22 p.m., the surveyor observed while ULP-N completed blood glucose testing and medication administration for R3, including oral medications and insulin. ULP-N's record lacked evidence a RN conducted direct supervision of ULP-N within 30 days of performing delegated tasks, as required. ULP-O ULP-O had a start date of August 9, 2021, to provide direct care services to residents of the facility. On June 21, 2023, at 8:23 a.m., the surveyor observed while ULP-O transferred R12 from the wheelchair to a recliner in the common area. ULP-O stated she provided medication administration to the residents she was assigned to care for. ULP-O's Staff Supervision Summary dated	01440			

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01440	Continued From page 34 August 9, 2021, through June 21, 2023, indicated a RN supervised ULP-O on July 27, 2022, or 352 days after hire, during medication administration. ULP-O's record lacked evidence a RN conducted direct supervision of ULP-O within 30 days of performing delegated tasks, as required. ULP-P ULP-P had a start date of April 4, 2022, to provide direct care services to residents of the facility. On June 21, 2023, at 8:15 a.m., the surveyor observed while ULP-P sat between two female residents at the dining room table, assisting each of them to eat breakfast. ULP-P's Staff Supervision Summary dated April 4, 2022 through June 21, 2023, indicated a RN supervised ULP-P on July 7, 2022, or 94 days after hire, during medication administration. ULP-P's record lacked evidence a RN conducted direct supervision of ULP-P within 30 days of performing delegated tasks, as required. ULP-Q ULP-Q had a start date of July 11, 2022, to provide direct care services to residents of the facility. On June 21, 2023, at 7:38 a.m., the surveyor observed while ULP-Q assisted residents entering the dining room for breakfast. ULP-Q stated she provided care for the residents assigned to her, including medication administration. ULP-Q's Staff Supervision Summary dated July 11, 2022, through June 21, 2023, indicated a RN supervised ULP-Q on September 29, 2022, or 80 days after hire, while using a sit-to-stand lift, full	01440			

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01440	Continued From page 35 body lift, a specialized positioning wheelchair, and an electronic scale. ULP-Q's record lacked evidence a RN conducted direct supervision of ULP-Q within 30 days of performing delegated tasks, as required. On June 22, 2022, at 12:22 p.m., corporate regional director (RD)-I stated ULP-B, ULP-O, ULP-N, ULP-P, ULP-Q, ULP-L's records lacked evidence of supervision within 30 days of performing delegated tasks, as required. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated August 1, 2021, indicated staff who provide delegated nursing or therapy tasks to the licensee's residents, will be supervised by a RN where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working and first performs the delegated tasks for residents and thereafter as needed, based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	01500			

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01500	Continued From page 36 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	01500		

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01500	Continued From page 37 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment 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: ULP-B's employee training records lacked evidence ULP-B had successfully completed annual training as required, to include the following: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise	01500			

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NAME OF PROVIDER OR SUPPLIER SILVERCREST PROPERTIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 RICE CREEK ROAD NEW BRIGHTON, MN 55112		
(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
01500	Continued From page 38 and protection of those rights; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. -In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: -an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; -the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. During interview on June 22, 2023, at 11:28 a.m., licensed assisted living director (LALD)-D indicated during the year of 2022, they did monthly training with different topics. LALD-D stated she "isn't going to sugar coat it, but all those topics may have not been touched on." LALD-D then indicated for this year, they have a new training program where the licensee received monthly email on topics to train the staff on.	01500			

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01500	Continued From page 39 The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated all staff performing direct care services would complete at least eight (8) hours of annual training for each 12 months of employment, and must include the following: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557. 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases. 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. The policy also indicated the licensee would retain a training record in the employee records to track compliance with annual training requirements. No further information was provided.	01500			

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01500	Continued From page 40 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=E	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 no more than 14 days after the initiation of services, for one of five residents (R5) as required, and failed to ensure	01620		

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01620	Continued From page 41 the RN completed an ongoing resident reassessment and monitoring as needed based on changes in the needs of the resident, not to exceed 90 calendar days from the last date of the assessment, for two of five residents (R5, R8). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R5 R5 was admitted for services on August 2, 2022. R5's diagnoses included dementia with behavioral disturbance, Barrett's esophagus (valve between stomach and esophagus is damaged, causing acid reflux and a change in the cells lining the lower esophagus), hepatic steatosis (excessive build-up of fat in the liver), osteoarthritis, osteopenia (loss of bone density), and hearing loss. R5's Service Plan (Private) - Addendum to Contract dated December 28, 2022, indicated R5 received services which included medication administration, assistance with activities, bathing, dressing, mobility, escorts, hearing aides, meals, toileting, and transferring. On June 21, 2023, at 9:38 a.m., R5 was sitting in his apartment, watching television, and didn't respond to surveyor's questions. Unlicensed	01620			

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01620	Continued From page 42 personnel (ULP)-M entered R5's apartment while the surveyor was in the room, and stated staff do frequent checks to make sure R5 was in his apartment or in the common area and was safe. ULP-M stated R5 had not had any recent falls or elopement attempts. R5's Assessment As Of Date dated August 2, 2022, was identified as the admission assessment. An Assessment As Of Date dated August 19, 2022, identified as the 14-day assessment, was completed 17 days after the initiation of services, instead of no more than 14 days after initiation of services, as required. R5's record contained an Assessment As Of Date dated September 9, 2022, identified as a clinical update assessment for correction of medication management documentation. The next Assessment As Of Date, identified as the 90 day assessment, was completed December 29, 2022, or 111 days from the last date of assessment, rather than not to exceed 90 days, as required. R5's Resident Notes - One Resident dated April 18, 2023, through June 15, 2023, indicated the following: - On April 18, 2023, at 7:55 p.m., licensed practical nurse (LPN)-G noted R5 "exhibited behaviors," attempted to elope from a secured unit, entered another resident's apartment, refused to leave, and demonstrated agitation, and several attempts by several staff members to redirect R5 were unsuccessful. R5 did leave the other resident's apartment on his own accord and was observed sitting in his chair in his apartment, without clothing on. R5 refused evening cares, food, beverages, and toileting assistance. - On April 21, 2023, at 9:44 a.m., RN-C noted staff were reporting an increase in R5's	01620			

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01620	Continued From page 43 restlessness, including ambulating with his walker in the hallways, entering other residents' apartments, and increase in behaviors such as urinating on carpet, getting undressed when in other residents' apartments, getting agitated when redirected by staff making it hard to approach at times. Nurse practitioner (NP) was updated by email. - On April 25, 2023, at 6:29 p.m., NP saw R5 and wrote an order to increase Buspar (anti-anxiety medication). - On May 8, 2023, at 3:00 p.m., care conference was held with R5's family members. They discussed R5's behaviors, including agitation, verbal aggression, swinging and slapping at staff, and disrobing. - On May 19, 2023, at 11:41 a.m., RN-C noted staff reported R5 had been refusing to be change clothing, refused peri-care, and had been walking in the hallways with just brief on. Staff attempted to redirect with eventual success by giving multiple cues and redirection. Staff also reported having daily problems with directing R5 to use the bathroom and to allow staff to provide peri-care. - On May 24, 2023, at 10:18 p.m., RN-R noted staff reported R5 was aggressive during cares, refused toileting multiple times and was hitting out during cares. NP updated. - On May 25, 2023, at 2:27 p.m., LPN-S noted R5 had increase in behaviors and was becoming more physically aggressive, kicking, and striking out at staff, difficult to redirect and refusing cares. NP updated. Orders received to check urinalysis/urine culture (UA/UC). - On May 25, 2023, at 7:27 p.m., RN-R noted R5 was seen by NP, received orders to draw lab work and if within normal range, increase Buspar. - On May 29, 2023, at 10:06 a.m., RN-C noted staff continued to report physical aggression toward caregivers, striking, pushing, and throwing	01620			

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01620	Continued From page 44 stool at staff. NP updated and new order received for Seroquel (antipsychotic) 12.5 milligrams (mg) to be given daily, as needed. - On June 1, 2023, at 2:04 p.m., LPN-S noted R5 was seen by NP for continued behaviors. R5's wife was present. Orders received for Seroquel 25 mg daily and 12.5 mg daily, as needed. - On June 8, 2023, at 5:11 p.m., RN-R noted staff reported R5 attempted to urinate in the garbage can in the dining area and when they attempted to redirect him, he attempted to hit them. R5 then began pacing down the hallway into other rooms. Attempts to redirect caused R5 to hit them. R5 was able to open the secured door to the stairwell with staff unsuccessfully attempting to control him, and he was escorted to the second level. Staff offered toileting, drinks, and food but he declined. R5 was offered and given the Seroquel and was able to calm down. - On June 9, 2023, at 10:40 a.m., RN-C documented NP was updated via phone and an order was received for more lab work. NP instructed to continue to administer Seroquel, as needed, over the weekend, and to report effectiveness at the next NP visit. - On June 13, 2023, at 11:49 a.m., LPN-S noted NP was updated that Seroquel administration was effective, and NP discussed with R5's family who agreed to increase dose. Orders received to increase Seroquel to 25 mg twice daily and continue order for as needed Seroquel. - On June 13, 2023, at 1:47 p.m., LPN-S noted NP was updated with abnormal UA results. At 7:58 p.m., LPN-G noted on-call doctor was updated with lab results. - On June 14, 2023, at 12:11 a.m., LPN-G noted staff reported R5's mood was pleasant and cooperative, required encouragement and assistance to complete cares with assist of two staff.	01620			

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01620	Continued From page 45 - On June 14, 2023, at 11:41 a.m., LPN-S noted UC results were negative for urinary tract infection. NP updated. - On June 15, 2023, at 12:02 a.m., LPN-S noted R5 displayed aggressive behaviors, refusing to allow staff to perform cares, toileting, and was non-responsive to redirection. R5 attempted to urinate in the kitchen sink and was escorted to the bathroom. Snacks and beverages were strongly refused, and several attempts were made to assist R5 with bedtime cares and to bed without success. R5's most recent Assessment As Of Date dated March 24, 2023, identified as 90 day/condition change assessment, indicated R5 had a history of becoming abusive, history of being verbally aggressive, and had a history of being resistive to cares. The assessment indicated R5 was taking Buspar for anxiety. R5's record lacked reassessment when R5 had an increase in aggressive behaviors and medications were added and readjusted. R8 R8's diagnoses included high blood pressure, hyperlipidemia (high level of lipids (fat) in the blood), and acute respiratory failure. R8's Service Plan (Private) - Addendum to Contract dated June 14, 2023, indicated R8 received services including assistance with dressing, meals, oxygen, toileting, safety checks, and medication administration. R8's Resident Notes - One Resident dated June 9, 2023, through June 14, 2023, indicated the following: -On June 9, 2023, at 3:12 p.m., LPN-S noted staff	01620		

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01620	Continued From page 46 called 911 and client was transported to the hospital; -On June 9, 2023, at 9:34 p.m., RN-R noted R8 was admitted for pneumonia and congestive heart failure; -On June 13, 2023, at 4:27 p.m., LPN-G noted R8's family notified facility hospice would be delivering hospice supplies and that R8 would be arriving home on oxygen. R8's family also requested scheduled toileting, medication administration, and help with activities of daily living; and -On June 14, 2023, at 3:46 p.m. RN-C noted R8 was re-admitted to licensee on hospice. R8's Assessment As Of Date dated June 3, 2023, assessed R8 was independent with activities of daily living including mobility, toileting, bathing, medication management, and had a standard bed. R8's Assessment As Of Date dated June 21, 2023, indicated R8 returned from hospital on hospice. The assessment noted RN-C completed the assessment on June 14, 2023, but it was signed by CNS-A on June 21, 2023. RN assessment indicated R8 needed help with bathing, dressing and grooming, mobility, oxygen, and toileting, but was independent with emergency evacuation, medication administration, and had a standard bed. On June 21, 2023, at 1:15 p.m., surveyor observed R8's hospital bed in the living room, an oxygen concentrator (machine that pulls in surrounding air and filters out the nitrogen) nearby and a commode (portable toilet) next to the bed. ULP-B set up and administered medications to R8.	01620			

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01620	Continued From page 47 On June 23, 2023, at 3:30 p.m., interim clinical nurse supervisor (CNS)-A stated resident assessments and reassessments should be completed timely, as required. CNS-A stated executive director of Reflections (secured memory care unit) (EDR)-T would sometimes complete a non-nursing, behavioral reassessment for a change in behavior; however, stated she did not know if this was completed. CNS-A stated nursing staff were expected to complete a resident reassessment when residents returned from hospitalization, had a new diagnosis, had a significant fall or wound, medication change, or had an issue "outside their norm." CNS-A stated a reassessment should have been completed for R5 when he displayed an increase in behaviors requiring a change in his medications. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services, and 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01710 SS=D	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 48 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) completed face-to-face medication management re-assessment for a change in condition for one of five residents (R8). 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 June 20, 2023, at approximately 10:20 a.m., interim clinical nurse supervisor (CNS)-A confirmed the licensee provided medication management services for residents. R8 admitted to the licensee for services on February 28, 2023. R8's diagnoses included high blood pressure, hyperlipidemia (elevated lipids (fat) in blood), acute respiratory failure and pneumonia. R8's Service Plan (Private)-Addendum to Contract signed June 14, 2023, indicated R8 received assistance with personal cares,	01710			

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01710	Continued From page 49 medication management, meal assistance, oxygen assistance, toileting, and safety checks. On June 21, 2023, at 1:15 p.m., surveyor observed ULP-B set up and administer the following medications to R8: -quetiapine 25 mg (milligrams) tab-1/2 tab (12.5 mg) by mouth twice per day for agitation; and -oxycodone 5 mg tab-1 tab by mouth three times per day for pain. R8's prescriber orders dated June 14, 2023, and June 19, 2023, included but were not limited to, two anti-hypertensives, one blood thinner, two anti-agitation medications, one strong pain reliever, one mild pain reliever, one anti-delirium medication, one anti-nausea medication, and one stool softener. R8's Assessment As Of Date dated June 21, 2023, indicated R8 returned from hospital on hospice. The assessment noted RN-C completed the assessment on June 14, 2023, but it was signed by CNS-A on June 21, 2023. RN assessment indicated R8 was independent with medication administration. R8's record lacked an RN medication management re-assessment for a change in condition (hospice). R8's Med Admin Summary dated June 2023, indicated R8 began receiving medication administration upon return from hospital on June 14, 2023. On June 22, 2023, at 9:37 a.m., interim clinical nurse supervisor (CNS)-A stated both her and RN-C both reviewed R8's RN comprehensive assessment and CNS-A signed the assessment on June 21, 2023, which was started by RN-C on June 14, 2023. CNS-A stated the assessment	01710			

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01710	Continued From page 50 should have included an updated medication management services assessment and plan. The licensee's 7.01 Medication Management-Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated prior to providing medication management services, an RN would conduct an assessment to determine what medication management services would be provided and how the services would be provided. The policy indicated the RN would do the following: -assessment must be conducted face-to-face with the resident by an RN; -assessment must include an identification and review of all medications the resident is known to be taking; -review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; -assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident and legal or designated representative on interventions to manage the resident's medications and prevent diversion of medications; and -{licensee} would monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			

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01730	Continued From page 51	01730		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730		

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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
01730	Continued From page 52 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of five residents (R8). 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 June 20, 2023, at approximately 10:20 a.m., interim clinical nurse supervisor (CNS)-A confirmed the licensee provided medication management services for residents. R8 admitted to the licensee for services on February 28, 2023. R8's diagnoses included high blood pressure, hyperlipidemia (elevated lipids (fat) in blood), acute respiratory failure and pneumonia. R8's Service Plan (Private)-Addendum to Contract signed June 14, 2023, indicated R8	01730			

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01730	Continued From page 53 received assistance with personal cares, medication management, meal assistance, oxygen assistance, toileting, and safety checks. On June 21, 2023, at 1:15 p.m., surveyor observed unlicensed personnel (ULP)-B set up and administer the following medications to R8: -quetiapine 25 mg (milligrams) tab-1/2 tab (12.5 mg) by mouth twice per day for agitation; and -oxycodone 5 mg tab-1 tab by mouth three times per day for pain. R8's Assessment As Of Date dated June 21, 2023, indicated R8 returned from hospital on hospice. The assessment noted RN-C completed the assessment on June 14, 2023, but it was signed by CNS-A on June 21, 2023. RN assessment indicated R8 was independent with medication administration. R8 lacked a service plan to include a written statement of the medication management services the resident received. In addition, R8's medication management record did not include the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions, - documentation of specific resident instructions relating to the administration of medications, - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis, - identification of medication management tasks that may be delegated to ULP, - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services,	01730			

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01730	Continued From page 54 - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions, and - completion of medication reconciliation. On June 22, 2023, at 9:37 a.m., interim clinical nurse supervisor (CNS)-A stated both her and RN-C both reviewed R8's RN comprehensive assessment and CNS-A signed the assessment on June 21, 2023, which was started by RN-C on June 14, 2023. CNS-A stated the assessment should have included an updated medication management services assessment and plan. The licensee's 7.01 Medication Management-Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated prior to providing medication management services, an RN would conduct an assessment to determine what medication management services would be provided and how the services would be provided. The policy indicated the RN would do the following: -assessment must be conducted face-to-face with the resident by an RN; -assessment must include an identification and review of all medications the resident is known to be taking; -review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; -assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident and legal or designated representative on interventions to manage the resident's medications and prevent	01730			

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01730	Continued From page 55 diversion of medications; and -{licensee} would monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=H	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the nursing task of medication administration, the unlicensed personnel (ULP) demonstrated competency to a registered nurse (RN) for administering medications for one of three ULPs (ULP-B). This practice resulted in a level three violation (a	01750			

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01750	Continued From page 56 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). This resulted in an immediate order on June 23, 2023, at approximately 2:10 p.m. The findings include: ULP-B was hired on August 1, 2021, to provide direct care services to residents of the assisted living with dementia care facility, for the residents that live in the unsecured area. On June 21, 2023, at 10:35 a.m., regional director (RD)-I stated the current management company for this licensee began providing services for the residents as of August 1, 2021, and at that time, all existing employees completed orientation and training as if they were new employees. The orientation included one full day of general orientation training for all staff, at the corporate office, and then on the second day, unlicensed personnel completed medication administration training and competencies for delegated tasks, at the facility. ULP-B's education transcript, printed June 21, 2023, at 10:38 a.m., indicated ULP-B had completed medication administration training (not competencies), via online modules on August 4, 2021. On June 21, 2023, at 1:15 p.m., the surveyor	01750			

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01750	Continued From page 57 observed ULP-B prepare R8's medications and administer to R8 in the resident's apartment. ULP-B stated she had worked at this facility under the previous owner and then for the current owner for a total of 23 years. ULP-B stated she could not recall being observed by a RN once she began working with the new licensee. Medications prepared by ULP-B included: - oxycodone 5 milligrams (mg) one tablet orally three times daily; and - quetiapine 12.5 mg one tablet orally every morning and afternoon. ULP-B's record lacked evidence ULP-B demonstrated the ability to competently follow the medication administration procedures as verified by the RN. On June 23, 2023, at 12:32 p.m., RD-I stated she was unable to find documentation that ULP-B had demonstrated competency to a RN for administration of medications. RD-I stated a timecard confirmed ULP-B attended the new employee general orientation on day one, however, RD-I could not verify ULP-B attended the medication administration training and skills assessment orientation. ULP-B's record included a document titled General Orientation Checklist For New Employees, signed August 1, 2021, however, the document did not include medication administration as a topic that was completed. On June 23, 2023, at 1:34 p.m., corporate clinical director, serving as interim clinical nurse supervisor (CNS)-A, stated when the licensee began providing services on August 1, 2021, all staff were expected to attend new employee orientation, which included medication	01750			

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01750	Continued From page 58 administration training, and were expected to demonstrate competency to the RN before giving medications to residents. CNS-A stated her expectation was that this was completed for all staff providing medication administration. CNS-A stated she could not explain why this didn't occur for ULP-B. The licensee's 6.14 Delegation of Assisted Living Services policy dated August 1, 2021, indicated a RN may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota Practice Act. The policy also indicated, when medication management is delegated to a ULP, the RN will: -instruct the ULP in the proper methods to administer the medications; and -verify the ULP has demonstrated the ability to competently follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy of order 1750 was removed on June 23, 2023, based on supervisor review. The scope and level remain the same.	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of	01760			

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01760	Continued From page 59 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 verify accuracy of prescriber orders when transcribing orders and failed to ensure medications were administered according to manufacturer's guidelines for one of five residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 20, 2023, at 10:25 a.m., licensed assisted living director (LALD)-D and interim clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. R3's diagnoses included dementia, Alzheimer's disease, and diabetes. R3's Service Plan (Private) - Addendum to	01760			

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01760	Continued From page 60 Contract dated May 3, 2023, indicated R3 received services including assistance with bathing, dressing, nail care, behavior monitoring, safety checks, toileting, transferring, medication administration, and blood glucose monitoring twice daily. R3's Assessment As Of Date dated May 1, 2023, indicated facility staff would manage and administer R3's oral medications and insulin, and indicated R3 always cooperated with medication administration and preferred to take medications "Whole pills with water." R3's prescriber orders signed May 2, 2023, included Lantus (long acting insulin) Solostar injection 100 units/milliliter subcutaneous (under the skin), "as needed" at 5:00 p.m.; however, directions included, "Prime pen with 2 units; Inject 8u (units) subcutaneously daily (dx: [diagnosis] diabetes mellitus). Alternate site." Also included, metformin (controls high blood sugars) 1000 milligrams (mg) one tablet by mouth twice daily. R3's Med (medication) Admin (administration) Summary dated June 2023, included "Lantus Solos [Solostar] Inj [injection] 100/MI [milliliters] (Daily) Prime pen with 2 units; Inject 8u subcutaneously daily (dx: diabetes mellitus). Alternate site;" however, was listed under the "PRN [as needed] Medications" and had no initials to indicate it had been given. The "Scheduled Medications," included Novofine Aut (autocover) Mis (type of disposable needle) 30g (gauge-size) x 8 mm (millimeters) (Daily), and indicated, "Use as directed with lantus daily," and was scheduled for 5:00 p.m. Initials were noted on each day. The Med Admin Summary also indicated, "Metformin Tab 1000 mg (Daily) 1 [one] tablet enterally [by mouth] 2 [two] times daily,"	01760			

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01760	Continued From page 61 scheduled to be given at 8:00 a.m., and 4:01 p.m. On June 21, 2023, at 2:42 p.m., registered nurse (RN)-C stated she was unaware of why R3's Lantus insulin was transcribed as a PRN medication and would look into this. At 3:57 p.m., RN-C stated R3 had a condition change in March 2023, and stated "the insulin switched on March 27, 2023, in the computer, from daily to PRN;" however, RN-C stated she could not find an order to verify this. RN-C described it as a "possible glitch" and could not explain why this happened. RN-C stated she was certain the insulin was being given by the staff because R3's Lantus pen, in use, was opened June 6, 2023, and approximately 40 units had been given out of it. RN-C stated she was waiting for a call back from R3's medical provider. At 4:10 p.m., RN-C stated she had spoken to R3's nurse practitioner and verified Lantus insulin should be given daily at 5:00 p.m. RN-C stated she had revised the order to indicate daily Lantus, and transcription was now correct. RN-C directed unlicensed personnel (ULP)-N to administer the insulin as ordered. On June 21, 2023, at 4:10 p.m., the surveyor observed while ULP-N conducted R3's blood glucose testing and stated the results were "219." ULP-N documented the results on the tablet and stated she would wait to give R3's insulin until she talked to the nurse. ULP-N proceeded to give R3's oral medications. ULP-N stated R3 was on a mechanical soft diet and would sometimes hold her oral medications under her tongue. ULP-N went to the refrigerator and grabbed a container of applesauce, used a device to crush R3's metformin tablet, and poured the crushed metformin into the applesauce. ULP-N gave R3 a spoonful of the applesauce mixed with the metformin. R3 refused any further spoonful of the	01760			

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01760	Continued From page 62 applesauce mixed with the metformin, and stated "Don't give me anymore of that, it's so sweet." ULP-N stated she would reapproach R3 later, covered the applesauce with the remaining metformin with plastic wrap, and put the container in the unit kitchenette refrigerator. ULP-N found a scrap of paper, wrote R3's name, and went to the refrigerator to label the applesauce container. ULP-N dropped the container on the floor, splashing applesauce with metformin on the floor and cupboards. ULP-N picked up the container, taped the paper with R3's name to the container, and placed it back in the refrigerator. At 4:37 p.m., ULP-N attempted to call the nurse on duty, on the telephone, with no answer. At 4:43 p.m., ULP-N began serving the evening meal to the residents. At 4:55 p.m., ULP-N called licensed practical nurse (LPN)-G on the walkie talkie and asked that she come up to the unit. At 4:58 p.m., LPN-G arrived on the unit and ULP-N asked if she should give the insulin. LPN-G directed ULP-N to give the insulin as ordered. ULP-N described the situation with attempting to administer R3's metformin, and LPN-G directed ULP-N to throw away the container in the refrigerator and to document the partial refusal. On June 21, 2023, at 5:23 p.m., ULP-N stated she recalled being trained to give medications by a nurse. When the surveyor asked how she knew which medications were okay to crush, ULP-N stated she had asked the nurses, and was told she could. ULP-N stated, "I'm kind of a little nervous." On June 22, 2023, at 2:50 p.m., CNS-A stated she had scheduled ULP-N for medication administration reeducation. The manufacturer's prescribing information dated	01760			

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01760	Continued From page 63 May 2018, included, "Swallow GLUCOPHAGE [same as metformin] XR [extended release] tablets whole and never crush, cut or chew." The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated an assessment must be conducted face-to-face with the resident by a RN, and the facility would monitor and reassess the resident's medication management services as needed when the resident presented with symptoms or other issues that may be medication-related and, at a minimum, annually. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated the facility would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain documentation of specific resident instructions relating to the administration of medications, and any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated June 20, 2021, indicated the RN would create and maintain a correct and accurate medication record for each resident receiving medication assistance or administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

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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 interview and record review, the licensee failed to ensure documentation of medication setup was completed accurately at the time of set up for three of three residents (R8, R9, R10). 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 June 20, 2023, at 10:25 a.m., licensed assisted living director (LALD)-D and interim clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents; however, did not know if the nurses were providing weekly medication set up for later administration by unlicensed personnel (ULP) for any of the residents. The surveyor requested nursing staff notify the surveyors if they were preparing to complete medication set up during the survey, so surveyors could observe the	01770			

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NAME OF PROVIDER OR SUPPLIER SILVERCREST PROPERTIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 RICE CREEK ROAD NEW BRIGHTON, MN 55112		
(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
01770	Continued From page 65 process. On June 20, 2023, at 2:28 p.m., corporate regional director (RD)-I provided a list including R8, R9, and R10, indicating the nursing staff provided weekly medication set up for the residents. The surveyor again requested nurses notify the surveyors if they were preparing to complete medication set up during the survey, so surveyors could observe the process. R8 R8's diagnoses included high blood pressure, hyperlipidemia (high level of lipids (fat) in the blood), and acute respiratory failure. R8's Service Plan (Private) - Addendum to Contract dated June 14, 2023, indicated R8 received services including assistance with dressing, meals, oxygen, toileting, safety checks, and medication administration. R8's prescriber orders dated June 14, 2023, included: - acetaminophen (mild pain reliever) 325 milligrams (mg) one to two tablets by mouth (po) every six hours as needed; - amlodipine (treats high blood pressure) 2.5 mg one tablet po daily; - oxycodone (treat moderate to severe pain) 5 mg, give 1/2 tablet (2.5 mg) po every six hours as needed; - apixaban (prevent blood clots) 2.5 mg tablet po twice daily; - metoprolol tartrate (treats high blood pressure) 25 mg one tablet po twice daily; and - simvastatin (lowers cholesterol) 40 mg one tablet po at bedtime. R9	01770			

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01770	Continued From page 66 R9's diagnoses included diabetes, vitamin B12 deficiency, mild cognitive impairment, history of breast cancer, high blood pressure, and hyperlipidemia. R9's Service Plan (Private) - Addendum to Contract dated June 12, 2023, indicated R9 received services including safety checks and medication administration. R9's prescriber orders dated June 12, 2023, included: - cholecalciferol (supplement) 2000 unit tablet po daily; - donepezil (treat confusion) 10 mg tablet po daily; - letrozole (treat breast cancer) 2.5 mg po daily; - omeprazole (treat stomach and esophagus problems) 40 mg po daily; and - Otezla (treat arthritis) 30 mg po daily. R10 R10's diagnoses included Alzheimer's Disease, enteritis (inflammation) of large intestine, arthritis right knee, osteoporosis, esophageal reflux, osteoarthritis, high blood pressure, vitamin D deficiency, and hyperlipidemia. R10's Service Plan (Private) - Addendum to Contract dated May 30, 2023, indicated R10 received services including assistance with bathing, behaviors, dressing, grooming, safety checks, and medication administration. R10's prescriber orders dated June 1, 2023, included: - Caltrate 600 + D (supplement) one tablet po daily; - fluoxetine (antidepressant) 10 mg two capsules po daily;	01770			

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01770	Continued From page 67 - lisinopril hydrochlorothiazide (treat high blood pressure) 20-25 mg one tablet po daily; - metoprolol succinate (treat chest pain and high blood pressure) 50 mg one tablet po daily; and - vitamin D3 (supplement) 5000 unit one tablet po daily. R8, R9, and R10's records lacked documentation by the licensed nurse at the time of medication setup to include the date of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, and name of the person completing medication setup. On June 21, 2023, at 2:37 p.m., registered nurse (RN)-C stated the licensed practical nurse (LPN) that typically set up the medications was on vacation, so RN-C had already completed medication set up for the week, therefore, there would be no opportunity to observe the process. When asked to describe the process, RN-C stated she used the Medication Administration Record (MAR) while setting up the medications, as a "guide." RN-C stated she used daily medication organizers and put each medication into the appropriate slot, and then ULPs would administer the medications as ordered. When asked how she documented the completion of medication set up, RN-C stated she did not write it on the MAR, and she "maybe should have written it in the progress notes," but stated she did not. The licensee's 7.09 Medication Management-Dosage Box Setup policy, dated August 1, 2021, indicated when the licensed nurse completed setting up medications into the dosage box, the set-up would be documented on the MAR.	01770			

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01770	Continued From page 68 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of five 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) 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 June 20, 2023, at 10:25 a.m., licensed assisted living director (LALD)-D and interim clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. R5 was admitted for services on August 2, 2022.	01820			

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01820	Continued From page 69 R5's diagnoses included dementia with behavioral disturbance, Barrett's esophagus (valve between stomach and esophagus is damaged, causing acid reflux and a change in the cells lining the lower esophagus), hepatic steatosis (excessive build-up of fat in the liver), osteoarthritis, osteopenia (loss of bone density), and hearing loss. R5's Service Plan (Private) - Addendum to Contract dated December 28, 2022, indicated R5 received services which included assistance with activities, bathing, dressing, mobility, escorts, hearing aides, meals, toileting, transferring, and medication administration. On June 21, 2023, at 9:38 a.m., R5 was sitting in his apartment, watching television, and didn't respond to surveyor's questions. Unlicensed personnel (ULP)-M entered R5's apartment while the surveyor was in the room, and stated staff do frequent checks to make sure R5 was in his apartment or in the common area and was safe. ULP-M stated R5 had not had any recent falls or elopement attempts. R5's prescriber orders dated June 13, 2023, noted the following: - acetaminophen (mild pain reliever) 500 milligrams (mg) one tablet by mouth (po) three times daily; - apoeaquorin (supplement) 10 mg capsule po daily; - aspirin (prevent heart attacks) 81 mg chew and swallow one tablet po daily; - B complex-C (supplement) one po daily; - Buspar (antianxiety) 10 mg po twice daily; - cholecalciferol (supplement) 25 micrograms (mcg)-1000 units tablet po daily;	01820			

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01820	Continued From page 70 - diclofenac 1% (treat inflammation) gel apply 2 grams to skin four times daily as needed; - donepezil (treat confusion related to Alzheimer's disease) 10 mg po daily at bedtime; - Aquaphor (treat dry chapped skin) ointment apply topically twice daily as needed; - glucosamine chondritin complex (treat osteoarthritis pain) 1000 mg po twice daily; - lorazepam (treat anxiety) 0.5 mg po daily and every 8 hours as needed; - mupirocin 2% (treats bacterial skin infection) ointment apply topically three times daily; - olanzapine (treats severe agitation) 5 mg one tablet twice daily; - omeprazole (treats excessive stomach acid) 40 mg one capsule daily, one hour before meal; and - quetiapine (treats mental/mood conditions) 25 mg one tablet po daily, and 12.5 mg daily as needed. R5's Medication Admin (administration) Summary, dated June 2023, noted the following: - acetaminophen 500 mg two tablets three times daily (discrepancy from above order); - buspirone (same as Buspar) 10 mg one tablet po three times daily (discrepancy from above order); - Vitamin D3 (same as cholecalciferol) 25 mcg one tablet daily; - diclofenac 1% gel 2 grams topically to left knee and right shoulder twice daily (discrepancy from above order); - quetiapine 25 mg one tablet po twice daily (discrepancy from above order) and 12.5 mg daily as needed; - Eliquis (prevent blood clots) 5 mg one tablet twice daily (not on orders); and - nystatin (treat fungal infection) 100,000 unit/gram topical powder apply thin layer to groin twice daily until resolved and then as needed (not	01820			

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01820	Continued From page 71 on orders, and only listed once daily at 7:30 p.m.). The above ordered medications not listed on the Medication Admin Summary include apoeaquorin, aspirin, B complex-C, donepezil, Aquaphor, glucosamine chondritin complex, lorazepam, mupirocin ointment, olanzapine, and omeprazole. On June 22, 2023, at 2:50 p.m., CNS-A and registered nurse (RN)-C stated they could not explain the discrepancies when comparing the prescriber orders to the Medication Admin Summary. RN-C stated she would investigate and report back to the surveyor. On June 23, 2023, at 2:40 p.m., CNS-A provided MD (medical doctor) Orders signed June 23, 2023, and stated RN-C had R5's provider sign these orders today, rather than providing written or electronic orders for the medications the licensee was administering to R5. Review of the newly signed provider orders continued to include discrepancies when compared to the medications being provided to R5. The licensee's 7.17 Medication & Treatment Orders policy, dated August 1, 2021, indicated a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. The policy noted the RN was responsible for ensuring current, authorized prescriber orders for medications and treatments administered by staff were kept on file in the residents' records, would review all medication and treatment orders for progress, effectiveness, and necessity on a regular basis and with resident change of condition, and would audit the medication administration record and the treatment administration record for documentation compliance.	01820		

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01820	Continued From page 72 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure follow up procedures were provided to meet the resident needs, for one of one resident (R3) receiving blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01960			

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01960	Continued From page 73 The findings include: During the entrance conference on June 20, 2023, at 10:25 a.m., licensed assisted living director (LALD)-D and interim clinical nurse supervisor (CNS)-A stated the licensee provided treatment and therapy services to the licensee's residents, which included blood glucose monitoring. On June 21, 2023, at 4:10 p.m., the surveyor observed while unlicensed personnel (ULP)-N prepared to conduct R3's blood glucose testing. ULP-N gathered needed supplies from a large, locked box in R3's closet. ULP-N donned gloves, used an alcohol pad to clean R3's finger, and poked the finger with a lancet. ULP-N was unable to obtain a drop of blood from R3's finger, obtained a new lancet, and repeated the process. ULP-N was able to obtain a drop of blood, placed on the strip in the glucose monitor, and stated the results were "219." ULP-N documented the results on the tablet and prepared to give oral medications to R3. R3's diagnoses included dementia, Alzheimer's disease, and diabetes. R3's Service Plan (Private) - Addendum to Contract dated May 3, 2023, indicated R3 received services including assistance with bathing, dressing, nail care, behavior monitoring, safety checks, toileting, transferring, medication administration, and blood glucose monitoring twice daily. R3's prescriber orders, signed May 2, 2023, included record blood glucose daily, and was listed twice. Directions included "Wearing gloves and following the procedure, check blood glucose	01960			

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01960	Continued From page 74 and record. Notify RN [registered nurse] if: If Blood Glucose is less than 70 or greater than 300." R3's Vital sign (sic) - One record, dated May 1, 2023, through June 21, 2023, indicated: - On May 7, 2023, at 4:00 p.m., blood sugar result of 312; and - On June 11, 2023, at 4:00 p.m., blood sugar result of 365. R3's Resident Notes - One Resident, from January 1, 2023, through June 20, 2023, lacked documentation of the nurse being notified of the above blood glucose results. R3's Vitals Out of Range - Date Range report from May 1, 2023, through June 22, 2023, noted R3's blood glucose result was 312 on May 7, 2023, at 4:08 p.m.; however, indicated RN-C did not acknowledge the out-of-range result until May 9, 2023, at 9:39 a.m. Also noted, R3's blood glucose result was 365 on June 11, 2023, at 8:40 p.m.; however, indicated RN-C did not acknowledge the out-of-range result until June 12, 2023, at 10:00 a.m. On June 22, 2023, at 2:54 p.m., RN-C stated staff would alert her if she was in the building or would call to report when the resident's blood sugar was less than 70 or above 300; however, stated she wasn't sure if that occurred consistently. RN-C stated there should be a progress note written to indicate the nurse was notified. RN-C stated she reviewed abnormal vital signs every day on the electronic medical record dashboard; however, could not recall if she was notified by the staff, as ordered, about R3's blood glucose result being out of range.	01960			

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01960	Continued From page 75 The licensee's 7.05 Treatment & Therapy Management Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident that must include procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services. The licensee's 7.20 Medication & Treatment Orders policy dated August 1, 2021, indicated the licensed nurse would monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of five residents (R6) who received	01970			

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01970	Continued From page 76 treatments managed be the licensee. 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: During the entrance conference on June 20, 2023, at 10:30 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated the licensee provided treatment management services to the residents. During observation and interview on June 21, 2023, at 3:30 p.m., surveyor observed compression socks on both of R6's lower extremities. R6 indicated staff help him/her with application in the morning and removal at bedtime due to physical limitations. R6's diagnoses included, but were not limited to high blood pressure, post-polio syndrome (polio survivor developed new symptoms years later), and abnormalities of gait and mobility. R6's Service Plan (Private) - Addendum to Contract signed May 11, 2023, indicated R6 received services including assistance with dressing, vital signs, toileting, transfer assistance and application and removal of compression stockings. R6's Assessment As Of Date dated March 17, 2023, identified as the registered nurse (RN)	01970			

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01970	Continued From page 77 assessment, included "needs help with anti-embolism/compression stockings, on and off." R6's prescriber orders dated May 10, 2022, indicated "apply compression stockings every morning; take off every evening, rinse with warm water and hang to dry." R6's record did not include a current prescriber's orders for compression socks. During interview on June 22, 2023, at 12:31 p.m., CNS-A indicated she contacted R6's nurse practitioner (NP) and NP stated she was very certain she signed a new order for the compression sock. CNS-A stated they should have a copy on file. The licensee's 7.18 Medication & Treatment Orders-Renewal policy dated August 1, 2021, indicated treatment orders would be sent to the resident's authorized prescriber for signatures at least every 12 months or more frequently as needed. Policy also indicated the signed treatment order renewal would be placed in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the	02040			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20231	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2023
NAME OF PROVIDER OR SUPPLIER SILVERCREST PROPERTIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 RICE CREEK ROAD NEW BRIGHTON, MN 55112		
(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
02040	Continued From page 78 following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of the available documentation and interview was conducted on June 21, 2023, at approximately 12:00 p.m. Licensed Assisted Living Director (LALD)-D, Maintenance Technician (MT)-J, and Corporate Director of Environmental Services (DES)-K on the hazard vulnerability assessment for the physical environment of the facility. The record review indicated that the licensee had not performed a	02040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20231	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2023
NAME OF PROVIDER OR SUPPLIER SILVERCREST PROPERTIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 RICE CREEK ROAD NEW BRIGHTON, MN 55112		
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02040	Continued From page 79 hazard vulnerability assessment with mitigation factors on and around the property. During the interview, LALD-D, MT-J, and DES-K stated that the licensee had not performed a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the care and services according to the acceptable health care medical or nursing standards of two of two residents (R8, R11) with oxygen storage. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20231	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2023
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02310	Continued From page 80 On June 21, 2023, at 1:15 p.m., surveyor observed in R8's living room near a walkway, an oxygen cylinder secured in a transport cart and next to that was an unsecured, unused oxygen cylinder. On June 21, 2023, at 2:43 p.m., surveyor observed in R11's bedroom one oxygen cylinder secured in a transport cart on the right side of a piano near the door opening and on the other side of the piano was an unsecured, unused oxygen cylinder. On June 23, 2023, at 10:12 a.m., interim clinical nurse supervisor (CNS)-A stated she was unaware the oxygen cylinders were at the facility and unsecured for R8 and R11. CNS-A stated she had told hospice agencies she did not want oxygen cylinders at the facility and use oxygen concentrators instead. The Joint Commission's Oxygen Cylinders-Patient Residence Storage recommendation last updated on October 29, 2021, indicated the following: -secured in an appropriate stand to prevent tipping and physical damage; -placement away from heat sources; and -located with adequate ventilation. The licensee's 7.40 Oxygen policy dated August 1, 2021, indicated oxygen cylinders and vessels must always remain upright. Never tip an oxygen cylinder or vessel on its side or try to roll it into a new location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20231	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2023
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02310	Continued From page 81 days	02310			

Type: Full
Date: 06/20/23
Time: 13:30:08
Report: 1029231141

Food and Beverage Establishment Inspection Report

Page 1

Location:

Silvercrest Properties Llc
2700 Rice Creek Road
New Brighton, MN55112
Ramsey County, 62

Establishment Info:

ID #: 0038495
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517465602
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

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

TCS ITEMS IN 3 LEVEL REFRIGERATOR MEASURED IN DANGER ZONE TEMPERATURES AND WERE DISCARDED. UNCLEAR IF TEMPERATURE ABUSE WAS BEHAVIORAL OR MECHANICAL IN NATURE. INSTRUCTED ESTABLISHMENT TO VERIFY REFRIGERATOR'S ABILITY TO HOLD TEMPERATURE.

Comply By: 06/20/23

7-200 Toxic Supplies and Applications

7-201.11A ** Priority 1 **

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

MR. MUSCLE DEGREASER SPRAY CAN LODGED UNDER CONICAL SIEVE STRAINER, OTHER SPRAY CHEMICALS NEXT TO AND POINTED AT DRYING AREA WITH NO BARRIER. SIEVE MOVED DURING INSPECTION. INSTRUCTED ESTABLISHMENT TO SEPARATE CHEMICALS FROM DRYING AREA.

Comply By: 06/20/23

Type: Full
Date: 06/20/23
Time: 13:30:08
Report: 1029231141
Silvercrest Properties Llc

Food and Beverage Establishment Inspection Report

Page 2

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

ABUNDANCE OF INSECTS IN CEILING LIGHTING IN BASEMENT DRY STORAGE AREA.
INSECTS NOT MOVING AND ON PLASTIC SHIELDING BENEATH TUBE LIGHT BULBS.
INSTRUCTED ESTABLISHMENT TO ELIMINATE HARBORAGE CONDITIONS. ESTABLISHMENT
USES PEST CONTROL COMPANY.

Comply By: 06/30/23

Surface and Equipment Sanitizers

LACTIC ACID: = 1875 PP at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

HOT WATER: = at 168.8 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: BUTTER
Temperature: 39 Degrees Fahrenheit - Location: 2-DOOR UPRIGHT LINE
Violation Issued: No

Process/Item: SOUP
Temperature: 144 Degrees Fahrenheit - Location: VULCAN HOT HOLDING OVEN
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: SUPERIOR 2-DOOR UPRIGHT
Violation Issued: No

Process/Item: SLICED TOMATOES
Temperature: 41 Degrees Fahrenheit - Location: LINE PREPARATION COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 35 Degrees Fahrenheit - Location: LEVEL 2 REFRIGERATOR
Violation Issued: No

Process/Item: MILK
Temperature: 47 Degrees Fahrenheit - Location: LEVEL 3 REFRIGERATOR
Violation Issued: Yes

Process/Item: BUTTER
Temperature: 45 Degrees Fahrenheit - Location: LEVEL 3 REFRIGERATOR
Violation Issued: Yes

Type: Full
Date: 06/20/23
Time: 13:30:08
Report: 1029231141
Silvercrest Properties Llc

Food and Beverage Establishment
Inspection Report

Process/Item: YOGURT
Temperature: 39 Degrees Fahrenheit - Location: LEVEL 3 REFRIGERATOR
Violation Issued: No

Process/Item: BUTTER
Temperature: 41 Degrees Fahrenheit - Location: WALK-IN COOLER GARAGE LEVEL
Violation Issued: No

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

Conducted inspection in the presence Mariel Boeyink, Dining Director; Steve Cameron, Corporate Dining Director; and other staff members. Topics discussed with Mariel and Steve included highly susceptible populations, employee illness reporting and exclusion procedures, vomit/fecal matter cleanup, sanitizing, common contagious foodborne illness pathogens (e.g., salmonella, shigella, Shiga toxin-producing E. coli, hepatitis A virus, and norovirus), hygienic practices (e.g., handwashing), and general food safety practices (e.g., holding temperatures at or below 41°F and 135°F or above for TCS foods).

Main kitchen/server area was commercial in nature and in fair condition, excluding minor paint peeling, sealant missing between walls and counters, and partial popcorn ceiling over the last few feet of the server area where soup is hot held. Establishment has dry storage, walk-in cooler and freezer on the garage level. Establishment also has two satellite kitchenette areas: one on level 2 and one on level 3.

All identified issues were discussed with Mariel and Steve throughout the inspection. Inspection findings were conveyed to LoAnn Degagne, RN, Nursing Evaluator II, following the inspection and emailed to lead HRD surveyor Anna Bohnen, RN, Nurse Evaluator.

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 1029231141 of 06/20/23.

Certified Food Protection Manager: Mariel Heather Boeyink

Certification Number: FM74440 Expires: 10/27/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Mariel Boeyink
Dining Director

Signed:  _____
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231141

DEPARTMENT OF HEALTH

Minnesota Department of Health

Food, Pools, and Lodging Services

625 Robert Street North

St. Paul

No. of RF/PHI Categories Out

1

Date06/20/23

No. of Repeat RF/PHI Categories Out

0

Time In13:30:08

Legal Authority MN Rules Chapter 4626

Time Out

Silvercrest Properties Llc

Address2700 Rice Creek Road

City/StateNew Brighton, MN

Zip Code55112

Telephone6517465602

License/Permit #0038495

Permit Holder

Purpose of InspectionFull

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS=corrected on-site during inspection

R=repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

Risk factors (RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is not in compliance

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection

R= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

Food properly labeled; original container

Prevention of Food Contamination

38

X

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

Physical facilities installed, maintained, & clean

56

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date:06/23/23

Inspector (Signature)