DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 10, 2023

Licensee
Mills Manor
215 Tousley Avenue South
New York Mills, MN 56567

RE: Project Number(s) SL34596015

Dear Licensee:

On January 25, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the November 10, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Schoenecker@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

HHH

Electronically Delivered

December 13, 2022

Administrator
Mills Manor
215 Tousley Avenue South
New York Mills, MN 56567

RE: Project Number(s) SL34596015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 10, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000.

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division

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

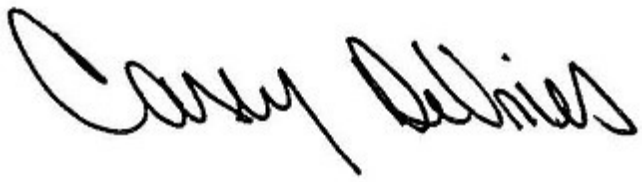
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34596	A. BUILDING: _____ B. WING _____	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLS MANOR	215 TOUSLEY AVENUE SOUTH NEW YORK MILLS, MN 56567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34596015-0 On November 7, 2022, through November 10, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 22 residents receiving services under the provider's Assisted Living license. An immediate correction order was identified on November 8, 2022, issued for SL34596015-0, tag identification 2310. On November 9, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, pattern violation.	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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements	0 460		

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0 460	Continued From page 1 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week, as required. This had the potential to affect all 22 residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 460		

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0 460	Continued From page 2 The findings include: The licensee held an assisted living license and was licensed for a bed capacity of 38 residents. Upon entrance to the facility, the main entrance door was locked. The surveyors observed a sign above a push button on the wall in the entryway, to the right of the door, that directed to push the button to enter during daytime hours. A doorbell was also available to push to summon staff for assistance to get into the building during evening and night hours. During the entrance conference on November 7, 2022, at approximately 11:00 a.m., when the surveyor asked how the residents summoned staff when needed, clinical nurse supervisor (CNS)-A and assisted living director in residence (ALDIR)-B stated all residents had a call light/pull cord in their room, and most residents were mobile and could seek out a staff member for help, if needed. During the initial tour of the facility with CNS-A on November 7, 2022, at 1:03 p.m., the surveyors observed the facility consisted of one level, with resident rooms on either side of the main hallway, and resident rooms located down three shorter hallways perpendicular to the main hallway, with a door leading to the outside at the end of each hallway. CNS-A stated each door leading outside was locked with a keypad code to exit, and the code was posted on each keypad. CNS-A stated the doors at the ends of the hallways were "never used by anybody." Between the nurse's station and the dining room was a common area where residents gathered, and included an entrance/exit area with two inner doors leading into a large entryway, with double doors leading to the	0 460		

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0 460	Continued From page 3 outside. There was a keypad on the left side of the innermost doors, with the required code posted on the keypad, that controlled the inner doors. The large doors leading to the outside had a bar across the middle of the door, that needed to be pushed to get out of the building, and the outside doors were not locked. CNS-A described the doors as the "smoking door," and stated two residents that lived in the facility, one male and one female, were "smokers," however, any of the residents could use the door to go out of the building. CNS-A further indicated the male resident smoked independently, and the female resident required assistance to smoke, including needing to ask for her smoking materials, because they were kept in the medication room, and stated she needed to be accompanied when going outdoors to smoke "for her safety." On November 8, 2022, at 8:30 a.m., the surveyors observed R7 driving a motorized scooter near the main entrance of the facility. R7 independently pushed the code on the keypad near the main front entrance of the facility, which unlocked the door, and then R7 pushed the plate on the wall that automatically opened the door, and exited the facility. R7 positioned himself within three to four feet to the right of the facility entrance, and was observed to use a lighter to light a short brown cigar. R7 independently returned into the building, pushing the button to open the door. On November 8, 2022, at 8:55 a.m., when the surveyor asked about R7 smoking next to the front entrance of the facility, assistant living director in residence (ALDIR)-B stated staff had been encouraging R7 to smoke in the designated smoking area; however, stated the front entrance "was easier" for him to get in and out of, due to	0 460		

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0 460	Continued From page 4 the automatic door plates. Throughout the remainder of the day on November 8, 2022, the surveyors observed R7 several times, to independently go in and out of the front entrance of the facility in his motorized wheelchair, and position himself to the right of the front entrance to smoke. On November 8, 2022, at 3:31 p.m., CNS-A stated R7 used the front entrance of the facility to smoke because the outside doors leading to the designated smoking area were heavy and difficult for a resident using a walker or a wheelchair to open, and there was a "bump" that was difficult to get over, and although R7 could get himself outside, he could not get himself back in. CNS-A stated staff had major concerns because there was no way for a resident to summon help out that door if they were to have difficulty getting the door open to get back in. CNS-A stated there was no doorbell or intercom system, and residents didn't have a device that they could notify staff of needing help. CNS-A stated she had notified the corporate office through phone calls, emails, and in person when they [corporate] were onsite, about her concerns regarding the doors in the designated smoking area, and stated it was "supposed to get fixed," but until then, she had compromised and allowed R7 to smoke outside of the main entrance. On November 9, 2022, at 9:20 a.m., the surveyors observed the doors leading outside to the designated smoking area, which were heavy when pushed and had a "lip" at the door, on the floor, approximately one inch higher at the base of the frame of the door to the cement. There was no handicap access button or doorbell at this entrance.	0 460		

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0 460	Continued From page 5 On November 9, 2022, at 9:25 a.m., the surveyor observed while unlicensed personnel (ULP)-J punched in the code on the keypad near the "smoking door" and held the doors open for R1 to exit out of the building for a cigarette. ULP-J lit R1's cigarette with a lighter, ensured R1 was situated on the seat of her four wheeled walker, and ULP-J returned inside the facility. ULP-J stated R1 was "okay" to smoke outside alone, but needed staff to escort outside because R1 couldn't remember the code on the keypad, even though it was posted. At 9:33 a.m., the surveyor observed R1 stand from the seat of the walker, walk three to four feet pushing the walker to the door and struggle to open the door while attempting to maneuver the walker out of the way of the door to get it open. R1 was able to wedge the walker between the door and the door frame to keep the door open; however, the weight of the door pushed against the walker and tipped the walker enough to lift the right wheels off the ground. R1 was able to hold the door, set the walker on four wheels and then push her way through the opening. Once inside the entryway, R1 pushed the button on the wall to unlock the door and again struggled to get the walker past the inner door and into the facility. R1 walked with the walker to the treatment cart, placed the lighter on top of the cart, and walked through the hallway to her room. R1 immediately sat on the bed, breathing heavily, and positioned an oxygen nasal cannula in her nostrils. On November 9, 2022, at 9:40 a.m., R1 stated the "door is heavy and tough to open while I'm trying to get my walker through." R1 stated she had "never gotten stuck outside," but worried about falling or not being able to get back in and "the girls getting busy" and not realizing she was	0 460		

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0 460	Continued From page 6 outside. R1 stated she did not know what she would do if that happened, because she had no way to call the staff to help her inside. On November 9, 2022, at 11:41 a.m., CNS-A stated staff walk R1 outside when she wants to smoke because she was was not able to unlock the door with the code, but R1 was able to come back into the facility by herself. CNS-A stated the process was concerning, however, because it was difficult for R1 to maneuver through the heavy doors due to unsteadiness and using her walker, and if she fell or got stuck, there was no means for R1 or any other resident to call for assistance. The licensee lacked a policy regarding providing a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week, when a summoning device was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and	0 480		

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0 480	Continued From page 7 fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 8, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following	0 500		

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0 500	Continued From page 8 and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel	0 500		

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0 500	Continued From page 9 performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 7, 2022, at 10:55 a.m., the surveyors requested to review the licensee's current policies and procedures. The licensee failed to ensure the following policies and procedures were in place and kept current: - medication and treatment management; - supervision of registered nurses (RN); and - supervision of unlicensed personnel performing delegated tasks. Throughout the survey, the surveyors made multiple requests to review the licensee's policies and procedures. However, the licensee failed to	0 500		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 500	Continued From page 10 provide the above required policies for review. On November 9, 2022, at 12:30 p.m., assisted living director in residency (ALDIR)-B stated the corporate office was telling her and clinical nurse specialist (CNS)-A what they could provide to the surveyors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of 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)-D) observed to provide medication administration.	0 510		

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	34596	A. BUILDING: _____ B. WING _____	11/10/2022

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0 510	Continued From page 11 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: On November 7, 2022, at 4:18 p.m., the surveyor observed ULP-D preparing to check R11's blood glucose prior to supper. ULP-D gathered the supplies out of the medication cart, donned gloves, and wheeled R11 into the beauty shop. ULP-D cleansed R11's finger with an alcohol pad, used a lancet to poke the finger, and placed a drop of blood onto the testing strip in the device. ULP-D set the used lancet directly on the table. ULP-D announced to R11 that her blood sugar result was 122. Without removing the gloves, ULP-D gathered the supplies, including the used lancet from the table, left the beauty shop touching the door, and walked to the medication cart. ULP-D placed the lancet in the sharps container, and without removing the soiled gloves, used a pen on top of the medication cart to write on a piece of paper, and used the computer mouse to find R11's sliding scale to determine the amount of insulin to give. ULP-D removed the gloves and tossed them into the trash attached to the medication cart, and without performing hand hygiene, put her hand into her pocket to get the keys for the medication cart. ULP-D unlocked the medication cart and opened the top drawer to find R11's insulin pen. ULP-D primed the insulin pen with two units of insulin, and dialed the insulin pen to 10 units. ULP-D asked ULP-K to verify the insulin dosage, typed	0 510		

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0 510	Continued From page 12	0 510		

on the computer keyboard, and donned a pair of gloves. ULP-D removed the testing strip from R11's glucometer, opened the bottom drawer of the medication cart, and without cleaning the glucometer, placed it in the drawer. ULP-D pushed the lock bottom on the medication cart, picked up the insulin pen and alcohol pad, and walked to the beauty shop. R11 had wheeled herself to the dining room, so ULP-D went to the dining room and wheeled R11 back to the beauty shop. ULP-D went into the bathroom, removed the gloves and without performing hand hygiene, attempted to don another pair of gloves. ULP-D stated she always had a hard time putting on new gloves when her hands were sweaty, and turned on the faucet to fill each glove with water. Once filled with water, ULP-D slid the gloves onto her hands and then turned her hands so the water would drain out of the gloves. ULP-D went to R11, cleansed the abdomen with the alcohol pad, and administered the insulin while water dripped from the gloves. Without removing the gloves, ULP-D touched the door handle, opened the door, allowed R11 to leave the room, and then pulled the handle on the outside of the door to close the door. ULP-D walked to the medication cart, removed the disposable needle from the insulin pen, and disposed it into the sharps container. ULP-D removed the gloves, reached into her pocket to retrieve her keys, unlocked the door behind the nurse's station, and washed her hands in the sink.

When interviewed on November 7, 2022, at 4:30 p.m., ULP-D stated she was trained when she was hired, by the previous nurse, and stated no one had ever observed her technique or told her she should do it differently.

On November 10, 2022, at 10:16 a.m., via

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0 510	Continued From page 13 telephone interview, clinical nurse supervisor (CNS)-A stated she would be providing re-education to ULPs regarding glove use, hand hygiene, and the correct procedure for donning and doffing gloves and would audit for compliance. The licensee's Hand Washing policy, effective September 27, 2021, directed proper hand washing techniques should be performed by all employees, as necessary. The policy also included, "When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves." The licensee's Infection Control Policy, effective October 6, 2022, directed facility staff would be trained upon hire and annually on infection control practices and on standard practices recommended as a part of routine healthcare delivery. The policy further directed the facility registered nurse was responsible to verify infection control practices were being followed and would meet with the assisted living director periodically to review. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:	0 640		

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0 640	Continued From page 14 (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety through access to the 911 emergency number as required. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 7, 2022, at 1:00 p.m., the surveyors toured the facility with clinical nurse supervisor (CNS)-A and noted there was no posting for the 911 emergency number in common areas. On November 7, 2022, at 1:20 p.m., CNS-A indicated no posting was noted with the required content. She stated some cordless phones had the 911 information posted on them, but they were kept in the offices.	0 640		

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0 640	Continued From page 15 The licensee's Safety - Emergency 911 Policy dated August 1, 2021, lacked information on the posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed	0 650		

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0 650	Continued From page 16 by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee records contained the required content for two of four employees (unlicensed personnel (ULP)-D and ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D was hired on September 10, 2021, to provide assisted living services. ULP-D's employee record lacked evidence of: - a current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. ULP-G ULP-G was hired on October 5, 2022, to provide assisted living services. ULP-G's employee record lacked evidence of:	0 650		

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0 650	Continued From page 17 - records of review of the provider's policies and procedures, handling of complaints, and a review of the types of services the employee would provide and the provider's scope of license; and - complete records of training to include reports of changes in condition to the supervisor, maintenance of a clean and safe environment, awareness of confidentiality and privacy, 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. On November 9, 2022, at approximately 3:20 p.m., assisted living director in residency (ALDIR)-B stated ULP-G had previously completed the training but was unable to provide documented evidence. In addition, ALDIR-B stated ULP-D's record lacked a job description with the required content. The licensee's Safety - Orientation of Staff and Supervisors & Content Policy dated August 1, 2021, noted evidence of completed orientation must be kept in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680		

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0 680	Continued From page 18 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness (EP) plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 680		

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0 680	Continued From page 19 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 initial tour with clinical nurse supervisor (CNS)-A on November 7, 2022, at 1:03 p.m., the surveyor's observed the facility's layout included one level, with resident rooms on either side of the main hallway, and resident rooms located down three shorter hallways perpendicular to the main hallway, with a door leading to the outside at the end of each hallway. The facility also included, a dining room, kitchen, staff offices, and common areas. Exit diagrams were posted in the hallways and in residents' rooms. There was no evidence of signage posted or information regarding the licensee's emergency plan, as required. On November 9, 2022, at 3:37 p.m., assisted living director in residence (ALDIR)-B provided the EP plan/binder, and stated the EP plan/binder was kept in the locked medication room. ALDIR-B stated the EP plan was not posted prominently, as required. The undated EP plan included several documents and policies contained in a three-ringed binder. The hazard vulnerability assessment listed potential vulnerabilities and included various policies/processes that addressed numerous natural and man-made emergencies, included emergency contact roster/list and numerous external emergency and service contacts, and included policies that directed the facility's training and testing program; however, lacked documentation of training or testing provided. The EP plan also lacked documentation of annual	0 680		

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0 680	Continued From page 20 review of the plan. On November 9, 2022, at 4:20 p.m., ALDIR-B and CNS-A stated, upon hire and annually, staff received training on the education software program regarding how to handle an emergency situation, but did not receive training on the licensee's EP plan. In addition, ALDIR-B and CNS-A stated they had participated in fire drills but had never participated in the testing of the EP plan, and were not aware of the annual testing requirements. The licensee's policy, Emergency Disaster Plan, dated August 1, 2022, indicated the licensee would have an emergency disaster plan that was in alignment with the facility's requirement to comply with Centers for Medicare and Medicaid Services (CMS) Appendix Z. The policy directed the Emergency Preparedness plan would be posted prominently in the facility. Also included, emergency and disaster training would be provided to all staff during the initial staff orientation and staff who had not received the training could only work when trained staff were working on site, and annual emergency and disaster training would be provided to all staff and residents. The policy lacked direction regarding annual testing requirements of the EP plan. The licensee's Training and Testing Program-Exercises policy, dated January 1, 2022, indicated the facility must participate in the following: - an annual full-scale exercise that is community based, or conduct an annual individual, facility-based functional exercise; - conduct an additional annual exercise that may include a full-scale exercise that is community based or an individual, facility based functional	0 680		

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0 680	Continued From page 21 exercise; or a mock disaster drill; or a tabletop exercise or workshop led by a facilitator; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events, and revise the facility emergency plan as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	0 800		

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0 800	Continued From page 22 residents). The findings include: On November 8, 2022, from approximately 10:00 a.m. to 1:35 p.m., survey staff toured the facility with Corporate Director of Maintenance (CDM)-E and Maintenance Technician (MT)-F. During the facility tour, survey staff observed the following: 1. A spot in the corner on the ceiling appeared to have moisture from a leak in resident room 316. 2. Multiple power taps and extension cords were daisy chained together in Mechanical room 60. 3. A light fixture globe cover was missing in storage room 47, along with several light fixture globe covers were missing in the basement level. 4. The electrical panel cover in basement mechanical room II-B was removed. 5. The exterior exit door, in dining area south wall, was rusted through at the bottom edge of the door. (CDM)-E and (MT)-F, verbally confirmed survey staff's observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
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.	01060		

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01060	Continued From page 23 (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; (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 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. 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	01060		

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01060	Continued From page 24 one of one resident (R3) 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: R3's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative 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. R3's diagnoses included atrial fibrillation, type 2 diabetes, and obesity. R3's Service Plan (Private) - Addendum to Contract, September 29, 2022, noted services including behavior management, blood sugar monitoring, and medication management.	01060		

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	34596	A. BUILDING: _____ B. WING _____	11/10/2022

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01060	Continued From page 25 R3's Resident Notes - One Resident included: - October 5, 2022, R3 had a worsening cough and was having difficulty conversing with staff without coughing. R3 was sent to the emergency room via ambulance, to be evaluated; - October 10, 2022, R3 remained in the hospital due to "unsteady hemoglobin levels and blood glucose levels;" and - October 13, 2022, R3 returned to the facility. On November 9, 2022, at 3:08 p.m., assisted living director in residence (ALDIR)-B and clinical nurse supervisor (CNS)-A stated the licensee was not currently providing a notice when residents were hospitalized and stated they were not aware the Office of Ombudsman for Long-Term Care needed to be notified if the resident was relocated and had not returned to the facility within four days. The licensee's Safety - Emergency Relocation Policy, effective/revised August 1, 2022, directed, in the event of an emergency relocation, the facility would provide a written notice that contained, at a minimum, the above required contents, and would be delivered 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		

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01470	Continued From page 26	01470		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any	01470		

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01470	Continued From page 27 training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include the required content for four of four employees (assisted living director in residency (ALDIR)-B, clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP-D, and ULP-G). 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:	01470		

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01470	Continued From page 28 ALDIR-B, CNS-A, ULP-D, AND ULP-G'S records lacked documented evidence of a review of the types of assisted living services the employee would be providing and the facility's category of licensure. ALDIR-B was hired on June 13, 2022, to provide assisted living services. CNS-A was hired on December 20, 2021, to provide assisted living services. ULP-D was hired on September 10, 2021, to provide assisted living services. ULP-G was hired on October 5, 2022, to provide assisted living services. On November 9, 2022, at 3:50 p.m., ALDIR-B and CNS-A stated no employees had received training on the above required content. The licensee's Safety - Orientation of Staff and Supervisors & Content Policy dated August 1, 2021, noted all staff must complete orientation before providing services to residents, including a review of the types of assisted living services the employee would be providing and facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the	01530		

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01530	Continued From page 29 following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of four employees (assisted living director in residency (ALDIR)-B) received the required amount of dementia care training in the required time frame. 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	01530		

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01530	Continued From page 30 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee provided services under an assisted living license. During the entrance conference on November 7, 2022, at 10:55 a.m., ALDIR-B and CNS-A stated the licensee did not have a secured dementia unit, but did provide services to residents with the diagnosis of dementia. ALDIR-B was hired on June 13, 2022, to provide assisted living services. ALDIR-B's employee record contained evidence of 7.5 hours of dementia training on hire, short of the required eight hours of training within 120 working hours. On November 9, 2022, at 3:43 p.m., ALDIR-B stated she reached 120 working hours on July 4, 2022, and stated she did the training that was assigned, which she indicated was short of the required amount. The licensee's Safety - Dementia Training Policy dated August 1, 2021, noted supervisors of direct care staff would complete eight hours of initial training within 120 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01620	Continued From page 31	01620		
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 to include an assessment of current smoking status for two of two residents (R7, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620		

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01620	Continued From page 32 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 initial tour of the facility with clinical nurse supervisor (CNS)-A on November 7, 2022, at 1:03 p.m., the surveyors observed the facility consisted of one level, with resident rooms on either side of the main hallway, and resident rooms located down three shorter hallways perpendicular to the main hallway, with a door leading to the outside at the end of each hallway. CNS-A stated each door leading outside was locked with a keypad code to exit, and the code was posted on each keypad. Between the nurse's station and the dining room was a common area where residents gathered, and included an entrance/exit area with two inner doors leading into a large entryway, with double doors leading to the outside. There was a keypad on the left side of the innermost doors, with the required code posted on the keypad, that controlled the inner doors. The large doors leading to the outside had a bar across the middle of the door, that needed to be pushed to get out of the building, and the outside doors were not locked. CNS-A described the doors as the "smoking door," and stated two residents that lived in the facility, R7 and R1, were "smokers." CNS-A further indicated R7 smoked independently, and R1 required assistance to smoke, including needing to ask for her smoking materials, because they were kept in the medication room, and stated she needed to be accompanied when going outdoors to smoke "for her safety."	01620		

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01620	Continued From page 33	01620		

R7
R7's diagnoses included seizure disorder, chronic pain, muscle weakness, depression, and dysphagia (difficulty swallowing).

R7's Service Plan (Waiver)-Addendum to Contract, dated September 16, 2022, noted R7 received services including activity assistance, behavior management, housekeeping, laundry, medication administration, intake monitoring, and monthly vitals and weight.

R7's Assessment As Of Date, dated September 16, 2022, included a section titled Safe Smoking, and indicated R7 was independent while smoking and had a smoking schedule. The assessment noted R7 was able to light, extinguish, and dispose of smoking materials in receptacle safely. Also included, R7's smoking materials were locked in the medication room so R7 must request staff to get the lighter and cigarettes, R7 was observed to smoke a cigar, and R7 could extinguish the cigarette completely. The assessment noted R7 was able to smoke safely, independently, and without intervention.

On November 8, 2022, at 8:30 a.m., the surveyors observed R7 propelling a motorized wheelchair near the main entrance of the facility. R7 independently pushed the code on the keypad near the main front entrance of the facility, which unlocked the first set of doors leading outside, and then R7 pushed the plate on the wall that automatically opened the door, and exited the facility. R7 positioned himself within three to four feet to the right of the facility entrance, and was observed to use a lighter to light a short brown cigar. R7 independently returned into the building, pushing the button to open the door. The

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01620	Continued From page 34 surveyors did not observe a receptacle in the area for R7 to extinguish the cigar, and the surveyors were unable to observe how R7 extinguished the cigar. On November 8, 2022, at 8:55 a.m., when the surveyor asked about R7 smoking next to the front entrance of the facility, assisted living director in residence (ALDIR)-B and CNS-A stated staff had been encouraging R7 to smoke in the designated smoking area; however, stated the front entrance "was easier" for him to get in and out of, due to the automatic door plates. When the surveyors asked how R7 extinguished his cigar, ALDIR-B stated, "We had a green thing out there for the guy," and stated someone must have moved it. CNS-A stated R7 usually extinguished the cigar and "brings it back in to smoke later;" however, CNS-A was not able to describe how R7 extinguished the cigar or if she could ensure the cigar was extinguished completely before bringing it into the facility. On November 8, 2022, at 9:18 a.m., the surveyors observed as R7 independently opened the main entrance door, and positioned himself within three to four feet to the right of the front entrance. R7 pulled a short, brown cigar from a vinyl pouch that was hung over the left handle on the motorized wheelchair and lit it with a lighter. After three puffs on the cigar, R7 held the cigar in his right hand and reached over the right side of the motorized wheelchair to extinguish the cigar on the front right tire of the wheelchair, and then switched the cigar to his left hand. R7 reached with his left hand to place the cigar in the vinyl pouch, and propelled himself back into the building. On November 8, 2022, at 10:25 a.m., and at	01620		

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01620	Continued From page 35 11:43 a.m., the surveyors observed as R7 went out the main entrance to smoke with the same process as noted above. On November 8, 2022, at 1:05 p.m., the surveyors observed as R7 independently went out the main entrance to smoke. R7 reached to the left side of his motorized wheelchair to grab the lighter and partially smoked cigar out of the vinyl pouch. R7 lit the cigar, smoked briefly, and then extinguished the cigar out on the right front tire of his motorized wheelchair. R7 placed the cigar into the vinyl pouch. At 1:10 p.m., the surveyor observed R7 return into the facility through the main entrance door and followed R7 to his room. R7 did not return his smoking materials to staff. R7 stated his smoking materials were stored in the nursing office, and stated he puts the cigar out on his wheelchair tire, and keeps what is remaining to smoke later. R7 stated, when the cigar was finished, he placed the butt in the receptacle outside. R7 stated he used the main entrance of the facility because it had a button to push to come back in, and stated he was unable to open or get in the door by the designated smoking area. On November 8, 2022, at 1:20 p.m., unlicensed personnel (ULP)-I stated R7 would come to get one cigar at a time to go out to smoke and was to return any unused portion to staff. ULP-I stated, at times, R7 smoked in the designated area and at times, smoked outside of the main entrance. ULP-I stated having observed R7 to put the cigar out on the ground to remove the "cherry." On November 8, 2022, at 3:31 p.m., the surveyor and CNS-A observed R7 smoking outside the main entrance and observed as he put the cigar out on the wheel of his wheelchair and placed the	01620		

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01620	Continued From page 36 partially smoked cigar into the vinyl bag on his chair. CNS-A stated she was aware that R7 would extinguish his cigar and bring it back in to smoke at a later time; however, stated she was unaware that he was putting it inside the vinyl pouch. CNS-A indicated she didn't know if the pouch was flame retardant. CNS-A stated R7 used the front entrance of the facility to smoke because the outside doors leading to the designated smoking area were heavy and difficult to open for a resident using a walker or a wheelchair, and there was a "bump" that was difficult to get over, and although R7 could get himself outside, he could not get himself back in. CNS-A stated she had notified the corporate office through phone calls, emails, and in person when they were onsite, about her concerns regarding the doors in the designated smoking area, and stated it was "supposed to get fixed," but until then, she had compromised and allowed R7 to smoke outside of the main entrance. CNS-A stated she had "major concerns" with R7 using the vinyl pouch to transport his smoking materials and with the door situation. CNS-A could not verify that the comprehensive assessment included observation of R7 during the entire process while smoking, and stated she was unaware that R7 wasn't following the smoking policy. On November 8, 2022, at 3:50 p.m., CNS-A and the surveyor entered R7's room. R7 stated he did place the cigar back in the vinyl pouch when he only smoked part of it, and two lighters were observed in the pouch at this time. No burn marks or holes were observed in the pouch. CNS-A removed the lighters and reminded R7 that all smoking materials were to be returned to staff, which he agreed to. R1	01620		

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01620	Continued From page 37 R1's diagnoses included diabetes, asthma, glaucoma, anxiety, chronic pain, and tobacco dependency. R1's Service Plan (Waiver)-Addendum to Contract, dated July 27, 2021, noted R1 received services including activity assistance, bathing assistance, dressing, grooming, oxygen maintenance, behavior management, housekeeping, laundry, medication administration, intake monitoring, monthly vitals and weight, and smoking assistance three times daily. R1's Assessment As Of Date, dated November 1, 2022, included a section titled Safe Smoking, and indicated R1 smoked two to three cigarettes per day and the smoking materials were stored in the locked medication room and given to resident "as designated." The assessment noted R1 disposed of ashes and cigarette butts in the ash receptacle, used a lighter, handled the lit cigarette responsibly, and extinguished the cigarette completely. The assessment noted R1 was able to smoke safely, independently, and without intervention, and included, "Resident supervised smoking activity and is determined to be a safe smoker at this time. Resident is on a strict smoking schedule. Reviewed and updated 3/25/21." The assessment indicated the smoking assessment was reviewed November 1, 2022, and included, "Reviewed 11/1/22-continues to be a safe smoker." On November 9, 2022, at 9:20 a.m., the surveyors observed the doors leading outside to the designated smoking area, which were heavy when and a "lip" was observed at the door, on the floor, approximately one inch higher at the base of the frame of the door to the cement. There was	01620		

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MILLS MANOR	215 TOUSLEY AVENUE SOUTH NEW YORK MILLS, MN 56567

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01620	Continued From page 38 no handicap access button or doorbell at this entrance. On November 9, 2022, at 9:25 a.m., the surveyor observed while ULP-J punched in the code on the keypad near the "smoking door" and held the doors open for R1 to exit out of the building for a cigarette. ULP-J handed R1 the cigarette and lighter and ensured R1 was situated on the seat of her four wheeled walker, and ULP-J returned inside the facility. ULP-J stated R1 was "okay" to smoke outside alone, but really liked when staff joined her outside. ULP-J indicated needing to escort R1 outside because R1 couldn't remember the code on the keypad, even though it was posted. At 9:33 a.m., the surveyor observed while R1 stood from the seat of the walker, turned the walker around, and took two or three steps to the right door (#5), opened the door with her left hand while her right hand held the walker. R1 placed the front right wheel of the walker in the opening of the door, pulled the door open further with her right hand, and pushed the walker through the opening as the door pushed against the walker. Once inside the entryway, R1 pushed the button on the wall to unlock the door and was able to get the walker past the inner door and into the facility. R1 walked with shuffling gait with the walker to the treatment cart, placed the lighter on top of the cart, and walked through the hallway to her room. R1 immediately sat on the bed, breathing rapidly and deeply, and positioned the oxygen nasal cannula lying on her bed, in her nostrils. On November 9, 2022, at 9:40 a.m., R1 stated she struggled to go outside for a cigarette and stated the "door is heavy and tough to open while I'm trying to get my walker through." R1 stated she had "never gotten stuck outside," but worried about falling or not being able to get back in and	01620		

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01620	Continued From page 39 "the girls getting busy" and not realizing she was outside. R1 stated she didn't know what she would do if that happened, because she had no way to call the staff to help her inside. On November 9, 2022, at 11:41 a.m., CNS-A stated staff walked R1 outside when she wanted to smoke because she wasn't able to unlock the door with the code, but R1 was able to come back into the facility by herself. CNS-A stated this process was concerning because it was difficult for any resident to maneuver through the heavy doors with unsteadiness and while using a walker; however, CNS-A could not verify that the comprehensive assessment included observation of R1 during the entire process while smoking, to include coming back into the facility without staff assistance. The licensee's Safety-Smoking Policy, printed November 8, 2022, directed residents would be assessed for safe smoking habits, would smoke in designated areas only, and would store smoking materials, lighters, and electronic cigarettes in designated area. The policy further directed a smoking observation would be completed by the Registered Nurse to determine smoking ability and would be documented in the resident's care plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 40 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all services identified in the service plan were implemented for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01640		

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01640	Continued From page 41 The findings include: R2's diagnoses included diabetes mellitus type 2. R2's Service Plan (Waiver) - Addendum to Contract dated November 8, 2021, indicated R2 received safety checks 17 times per day. R2's Modifications to the Service Plan dated July 1, 2022, indicated an increase in the fees, but no change in services. R2's prescriber orders dated December 7, 2021, noted safety checks 17 times per day. R2's Assessment As Of Date dated October 16, 2022, noted safety checks had been added as follows: - April 12, 2022 "Safety check implemented at 11:00 AM [a.m.]"; - May 5, 2022, "Safety check implemented at 3:00 AM"; - August 9, 2022, "Safety check implemented at 5:00 AM"; - September 5, 2022, "Safety check implemented at 2:00 PM"; - September 23, 2022, "Safety check implemented at 3:00 PM"; - October 3, 2022, "Safety check implemented at 6:00 PM"; - October 7, 2022, "Safety check implemented at 8:00 AM"; and - October 10, 2022, "Safety check implemented at 10:00 AM". R2's Services Delivered from November 1, 2022, through November 6, 2022, contained a documented 15 safety checks per day. On November 9, 2022, at 5:05 p.m., clinical nurse supervisor (CNS)-A indicated the safety checks	01640		

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01640	Continued From page 42 were documented 15 times per day, short of the ordered 17 times per day. CNS-A stated she had added multiple safety checks, so it should show more than 17, not less. The licensee's Safety - Service Plan Policy dated August 1, 2021, noted the facility would implement and provide all services indicated on the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber,	01690		

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01690	Continued From page 43 pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures that were developed under the supervision and direction of a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 7, 2022, at 10:55 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. At this time, the surveyors requested to review the licensee's current medication policies and procedures.	01690		

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01690	Continued From page 44 The licensee lacked the following policies: - requesting and receiving prescriptions for medications; - verifying that prescription drugs are administered as prescribed; - monitoring and evaluating medication use; - communicating with the prescriber, pharmacist, and resident and legal and designated representatives; - educating residents and legal and designated representatives about medications; and - when controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. Throughout the survey, the surveyors made multiple requests to review the licensee's policies and procedures. However, the licensee failed to provide the above required policies for review. On November 9, 2022, at 12:30 p.m., assisted living director in residency (ALDIR)-B stated the corporate office was telling her and clinical nurse specialist (CNS)-A what they could provide to the surveyors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01690		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 45 (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. (c) Medication reconciliation must be completed when a licensed nurse, licensed health	01730		

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01730	Continued From page 46 professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 7, 2022, at 10:55 a.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility. R2's diagnoses included diabetes mellitus type 2. R2's Service Plan (Waiver) - Addendum to Contract dated November 8, 2021, indicated R2 received services which included dressing assistance, medication administration, safety check, toileting, and transfer assistance. R2's prescriber orders dated October 17, 2022, included the following medications: two antidepressants, one thyroid replacement	01730		

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01730	Continued From page 47 hormone, and two insulins. R2's Individualized Medication Management Plan dated October 16, 2022, noted an assessment was completed to include the identification of all medications including indications, side effects, contraindications, adverse reactions, and actions taken. However, it lacked a medication reconciliation as required. On November 9, 2022, at 5:05 p.m., clinical nurse supervisor (CNS)-A indicated a medication reconciliation had not been documented in the resident's record. The licensee's Safety - Medication Management Individualized Plan Policy dated August 1, 2021, noted a medication reconciliation would be completed when a licensed nurse, licensed health professional, or authorized prescriber was providing medication management. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not	01760		

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01760	Continued From page 48 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were documented to include the correct information for two of four residents (R9, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R9 R9's diagnoses included acute ischemic stroke. On November 9, 2022, at 9:48 a.m., the surveyor observed unlicensed personnel (ULP)-H administer Tylenol 500 milligrams (mg) two tablets to R9 in his room. The label on the medication card noted one tablet. At this time, ULP-H stated nursing had been notified about this "a lot". R9's Service Plan (Waiver) - Addendum to Contract, dated November 17, 2022, indicated R9 received assistance with dressing, mobility, and medication administration.	01760		

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01760	Continued From page 49 R9's prescriber orders dated October 28, 2022, noted Tylenol 1,000 mg orally three times per day and as needed. On November 8, 2022, at 10:30 a.m., clinical nurse supervisor (CNS)-A stated she was not aware the card didn't match the prescriber's order, and stated the resident's order had just recently been changed and the card should have been changed. R2 R2's diagnoses included diabetes mellitus type 2. R2's Service Plan (Waiver) - Addendum to Contract dated November 8, 2021, indicated R2 received medication administration. R2's Modifications to the Service Plan dated July 1, 2022, indicated an increase in the fees, but no change in services. R2's prescriber orders dated October 17, 2022, noted the following sliding scale instructions: - 8:00 a.m., 12:00 p.m., and 4:00 p.m. - 0 - 200 = Give 0 units; - 201 - 250 = Give 2 units; - 251 - 300 = Give 4 units; - 301 - 350 = Give 6 units; - 351 - 400 = Give 8 units; and - Over 400 = Give 10 units. R2's prescriber orders dated October 20, 2022, noted "Continue Novolog sliding scale" with the note "Inject prescribed amount per sliding scale subcutaneously as directed four times per day." R2's October 2022 and November 2022 Med (Medication) Admin (Administration) Summary noted Novolog Flexpen sliding scale order as follows:	01760		

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01760	Continued From page 50 - 8:00 a.m., 12:00 p.m., and 4:00 p.m. - 0 - 200 = Give 0 units; - 201 - 250 = Give 2 units; - 251 - 300 = Give 4 units; - 301 - 350 = Give 6 units; - 351 - 400 = Give 8 units; and - Over 400 = Give 10 units. On November 9, 2022, at 1:55 p.m., CNS-A stated the provider signed the incorrect order on October 20, 2022, which noted the sliding scale four times per day, not the correct three times per day, and stated she was in the process of getting this clarified. The licensee's Safety - Medication Management - Administration & Setup Policy dated August 1, 2021, noted for medication administration, the documentation must include the medication name, dosage, date and time administered, and the method and route of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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	01770		

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01770	Continued From page 51	01770		

licensee failed to ensure documentation of medication setup included all the required content for one of one resident (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 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 November 7, 2022, at 10:55 a.m., clinical nurse supervisor (CNS)-A said the licensee provided no medication setups at this time.

On November 9, 2022, at 10:10 a.m., the surveyor conducted a review of the medication storage with unlicensed personnel (ULP)-H in what she identified as the main medication cart, which contained the narcotic medications in a locked compartment. The surveyor counted with ULP-H liquid morphine, setup in syringes with 0.25 mL in each syringe. Eight syringes were counted in the scheduled area, and 11 syringes in the as needed area. ULP-H stated the syringes were setup by the registered nurse.

R8's diagnoses included chronic kidney disease.

R8's Service Plan (Waiver) - Addendum to Contract dated July 14, 2022, indicated R8 received medication administration.

R8's prescriber orders dated October 25, 2022, noted Morphine Sulfate Concentrate 0.25

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MILLS MANOR	215 TOUSLEY AVENUE SOUTH NEW YORK MILLS, MN 56567

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01770	Continued From page 52 milliliters (mL) sublingually (sl) every four hours as needed for pain or dyspnea, and November 4, 2022, noted morphine 0.25 mL every four hours around the clock. R8's Med (Medication) Admin (Administration) Summary for November 2022 included the following notes: - November 1, 2022, "5 syringes filled with 0.25 mL equaling 1.25 mL subtracted from the bottle. 28.75 mL count implemented into care." - November 4, 2022, "13 syringes filled with 0.25 mL for scheduled dose. 3.25 mL subtracted from bottle. 22 mL count implemented into care." R8's record lacked complete documentation by the licensed nurse at the time of medication setup to include documentation of the times to be administered or the route of administration. On November 9, 2022, at 11:15 a.m., CNS-A indicated she did setup morphine for R8, and stated the documentation lacked the times to be administered and route of administration. She stated R8 was the only resident receiving medication setup. The licensee's undated Safety - Medication Management Policy noted documentation of medication setup would include the times to be administered and route of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01890 SS=F	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 53 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened for five of six residents (R1, R2, R10, R11, R12), failed to ensure medications were maintained bearing a prescription label for one of six residents (R3) with insulin, and failed to monitor for expired medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 November 7, 2022, at 10:55 a.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility. TIME SENSITIVE MEDICATIONS On November 9, 2022, at 10:10 a.m., the surveyor conducted a review of the medication	01890		

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01890	Continued From page 54 storage with unlicensed personnel (ULP)-H in what she identified as the main medication cart. R1's opened Humalog KwikPen lacked a date to indicate when staff opened it, or when it would expire. The manufacturer's instruction for use of Humalog KwikPen dated revised April 2020 noted "Do not use your Pen past the expiration date printed on the Label or for more than 28 days after you first start using the Pen." R2's opened Lantus SoloStar lacked a date to indicate when staff opened it, or when it would expire. R10's opened Lantus SoloStar lacked a date when opened or when it would expire. The manufacturer's instruction for use of Lantus SoloStar dated March 2020 noted for storage of the opened pen, "After 28 days, throw your opened Lantus pen away - even if it still has insulin in it." R11's opened Victoza lacked a date to indicate when staff opened it, or when it would expire. The manufacturer's instruction for use of Victoza dated September 2022 noted "After first use, store your Victoza pen for up to 30 days at 59°F to 86°F (15°C to 30°C) or in a refrigerator at 36°F to 46°F (2°C to 8°C)." R12's opened Novolog FlexPen lacked a date to indicate when staff opened it, or when it would expire. The manufacturer's instruction for use of Novolog	01890		

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01890	Continued From page 55 FlexPen dated revised March 2021 noted "Store the FlexPen you are currently using out of the refrigerator at room temperature below 86°F (30°C) for up to 28 days." On November 9, 2022, at 10:30 a.m., CNS-A stated all insulin pens should be dated when opened. PRESCRIPTION LABEL AND EXPIRED MEDICATIONS On November 9, 2022, at 10:12 a.m., the surveyor observed the medication storage room with ULP-I. The large medication refrigerator in the medication storage room contained several boxes of unopened insulin pens labeled with prescription labels. In the door of the refrigerator, a single Insulin Aspart Protamine & Insulin Aspart FlexPen (fast acting insulin) contained a small sticker that indicated an opened date of November 8, 2022; however, lacked a prescription label or a way to identify who the insulin pen belonged to. When asked, ULP-I stated she thought it belonged to R3, because he had a new medication that needed to be refrigerated. Also noted in the refrigerator was a Glucagon Emergency 1 milligram (mg) Kit with an expiration date of October 2022, and Florajen Digestion capsules (probiotics to help with digestion) with an expiration date of October 31, 2022. On November 9, 2022, at 10:31 a.m., CNS-A stated R3's medications were recently received from a new pharmacy, and she was aware that R3's individual insulin pens were not labeled with a pharmacy label. CNS-A stated she needed to contact the pharmacy to have this fixed. In addition, CNS-A stated it was everyone's responsibility to observe expiration dates of	01890		

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01890	Continued From page 56 medications and to remove medications that were expired. The licensee's Safety-Insulin Pen policy, printed November 7, 2022, noted, "Pen needs to be dated when first used. Follow manufacturer expiration dates for each pen. In addition, the policy directed to check label on the pen to be sure it contained the type of insulin that was prescribed by the physician and was the correct resident. The licensee's Safety - Medication Storage Policy dated August 1, 2021, noted, "A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time sensitive dated drug." The licensee's Safety-Medication Disposal Policy, effective August 1, 2021, indicated expired medications managed by the facility would be disposed of according to the accepted practices of the Minnesota Board of Pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The	01930		

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01930	Continued From page 57 policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 7, 2022, at 10:55 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided treatment	01930		

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01930	Continued From page 58 and therapy management services to the licensee's residents. At this time, the surveyors requested to review the licensee's current medication policies and procedures. The licensee lacked the following policies: - requesting and receiving orders or prescriptions for treatments or therapies; - educating and communicating with residents about treatments or therapies they are receiving; - monitoring and evaluating the treatment or therapy; and - communicating with the prescriber. Throughout the survey, the surveyors made multiple requests to review the licensee's policies and procedures. However, the licensee failed to provide the above required policies for review. On November 9, 2022, at 12:30 p.m., assisted living director in residency (ALDIR)-B stated the corporate office was telling her and clinical nurse specialist (CNS)-A what they could provide to the surveyors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01930		
02310 SS=H	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.	02310		

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02310	Continued From page 59 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for three of seven residents (R2, R5, and R6) with hospital-style bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). This practice resulted in an immediate order for correction on November 8, 2022. The findings include: R2 On November 8, 2022, at 9:33 a.m., the surveyor observed clinical nurse supervisor (CNS)-A measure R2's bilateral upper hospital bed rails affixed to the hospital bed. R2's head of bed was slightly elevated, both bed rails were in the raised position. The nine openings between the bars for zone 1 varied in size with the largest opening was 3.25 inches. The measurements between the mattress and the bed rail for zone 3, measured 1 inch. R2 was not in the room during the observation. The bed rail was tight with no movement. CNS-A stated R2 utilized the bed rails to get in and out of bed.	02310	On November 9, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, pattern violation.	

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02310	Continued From page 60 R2's diagnoses included diabetes mellitus type 2, chronic obstructive pulmonary disease (COPD), chronic pain syndrome, and hypertension. R2's Service Plan (Waiver) - Addendum to Contract dated November 8, 2021, indicated R2 received services which included dressing assistance, medication administration, safety check, toileting, and transfer assistance. R2's Assessment As Of Date dated October 16, 2022, noted R2 had a hospital bed with partial bilateral bed rails to aid in transfers to and from bed and to aid in turning and repositioning. It noted bed rails were on the upper bed bilaterally to promote and encourage independence with bed mobility and to turn and reposition when in bed, and with transfers to and from the bed. In addition, it noted risk versus benefits had been reviewed with the resident and responsible party, and the acknowledgement had been signed. R2's record lacked a comprehensive assessment of the hospital bed rails to include the measurements of zones 1, 2, and 3 of the Food and Drug Administration (FDA) guidelines and lacked evidence of physical inspection of the bed rail and mattress for areas of entrapment and stability of the device. R5 On November 8, 2022, at 9:43 a.m., the surveyor observed CNS-A measured R5's bilateral upper hospital bed rails affixed to the hospital bed. R5's head of bed was slightly elevated, both rails were in the raised position. The bedrails were brown metal with five vertical openings and four horizontal openings on each end. The openings between the bars for zone 1 varied in size with the largest opening at 2.25 inches. The	02310		

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02310	Continued From page 61 measurements between the mattress and the bed rail for zone 3, measured 2 inches. The bed rail on the right side of the bed was tight with little movement. However, the left bed rail was loose with significant movement from side to side and up and down. R5 was in the room at the time of the observations but was non-verbal and smiled when asked questions. R5's diagnoses included spastic quadriplegic cerebral palsy, cervical spinal stenosis, hypertension, and posterior neck pain. R5's Assessment As Of Date dated October 7, 2022, noted R5 had a hospital bed with bed rails bilaterally to promote and encourage independence with bed mobility, turning and repositioning in bed, and transfers to and from bed. R5's Service Plan (Waiver) - Addendum to Contract dated October 7, 2022, noted R5 received services including assistance with bathing, incontinent care, medication administration, toileting, and transfer assistance. R5's record lacked a comprehensive assessment of the hospital bed rails to include the measurements of zones 1, 2, and 3 of the FDA guidelines and lacked evidence of physical inspection of the bed rail and mattress for areas of entrapment and stability of the device. R5's record also lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative. Additionally, the record lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device.	02310		

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02310	Continued From page 62 R6 On November 8, 2022, at 9:49 a.m., the surveyor observed CNS-A measure R6's bilateral upper hospital bed rails affixed to the hospital bed. R6's head of bed was flat, with the right bed rail in the raised position, and the left bed rail (next to the wall) was in the lowered position. The bed rails were a light colored rectangular shaped with four openings. The openings between the bars for zone 1 for each opening measured 12 1/2 inches wide. The top two openings measured 4 inches tall, and the bottom two openings measured 4.5 inches tall. The measurements between the mattress and the bed rail for zone 3, measured 1.25 inches. The bed rail was tight with no movement. R6 was not in the room at the time of the observation. R6's diagnoses included hypertension, atrial fibrillation, and dizziness. R6's Service Plan (Waiver) - Addendum to Contract dated July 25, 2022, noted R6 received services which included assistance with ambulation, bathing, dressing, and medication administration. R6's Assessment As Of Date dated October 18, 2022, noted R6 had a hospital bed with partial bilateral bed rails to promote and encourage independence with bed mobility, turning and repositioning in bed, and transfers to and from bed. It noted no alternatives were available for use. In addition, the assessment noted for zone 1, "Length is outside of regulation. Resident is aware of risks and wishes to continue with use of bed rails." It also noted zone 2 and zone 3 were less than 4.75 inches. R6's record lacked a comprehensive assessment	02310		

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02310	Continued From page 63 of the hospital bed rails to include the measurements of zones 1, 2, and 3 of the FDA guidelines. The record lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. On November 8, 2022, at 8:50 a.m., CNS-A stated any staff and family members are to notify the nurse of any new equipment brought into the facility. The registered nurse (RN) would then complete an assessment to include measurements of the bed rails, determine if they are appropriate and safe, within the FDA guidelines, and provide a risk versus benefits form. CNS-A reviewed the assessments for R2, R5, and R6 and stated the assessment should include the measurements, and said R2, R5, and R6's assessments lacked the required content. In addition, CNS-A stated the facility policy was to include the measurement of the zones per FDA guidelines. The licensee's undated Safety - Siderails (bed rails)/Grab Bar Policy noted when the facility was aware a resident utilized bed rails on a bed, the RN would assess the use, educate the resident, and when appropriate, resident/responsible person, regarding the risk and benefits of bed rails, and verify the bed rail in use was of safe design and utilized consistent with the manufacturer's directions. In addition, the policy noted staff would determine if the bed rail was considered to be safe, defined as meeting all of the requirements, including, if the bed rail was used according to the manufacturer's directions, the bed rail was installed securely and maintained in good operating conditions, and the bed rail design was consistent with the FDA's 2006 recommended dimensional measurements to	02310		

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02310	Continued From page 64	02310		

reduce entrapment. This means bed rail zones must not exceed 4.75 inches. The policy also noted the resident/resident's representative would be informed of the risk versus benefits of using the bed rail and documented in the resident's record.

The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:
- Purpose and intention of the bed rail;
- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;
- The resident's bed rail use/need assessment;
- Risk vs. benefits discussion (individualized to each resident's risks);
- The resident's preferences;
- Installation and use according to manufacturer's guidelines;
- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and
- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".

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MILLS MANOR	215 TOUSLEY AVENUE SOUTH NEW YORK MILLS, MN 56567

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02310	Continued From page 65 Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

Minnesota Department of Health

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

Type: Full
Date: *11/08/22*
Time: 10:40:52
Report: 1008221052

Food and Beverage Establishment Inspection Report

Location:
Mills Manor
215 Tousley Avenue South
New York Mills, MN56567
Otter Tail County, 56

Establishment Info:
ID #: 0038745
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183854700
ID #:

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

The following orders were issued during this inspection.

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

3-302.13 ** Priority 1 **

MN Rule 4626.0245 Discontinue use of unpasteurized eggs or egg products in the preparation of food such as Caesar salad, hollandaise or bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages, and other foods that are not cooked as specified in 4626.0340.

NON PASTEURIZED EGGS WERE STORED IN WALK-IN COOLER. DISCUSSION WITH KITCHEN STAFF AS TO HOW EGGS ARE USED WITHIN ESTABLISHMENT. DISCONTINUE TO USE NON PASTEURIZED EGGS WITH A HIGHLY SUSCEPTIBLE POPULATION.

Comply By: 11/09/22

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COULD NOT FIND THE THERMOMETER IN THE TWO DOOR COOLER. PROVIDE A THERMOMETER IN THIS COOLER.

Comply By: 11/10/22

Surface and Equipment Sanitizers

Hot Water: = at 175 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Spray bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 171 Degrees Fahrenheit - Location: Beef Stew
Violation Issued: No

Process/Item: Upright Cooler - 2 Door
Temperature: 41 Degrees Fahrenheit - Location: Bacon
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 41 Degrees Fahrenheit - Location: salad
Violation Issued: No

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

THINGS TO REMEMBER:

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

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

3 THERE SHOULD BE A PERSON IN CHARGE A THE ESTABLISHMENT DURING ALL HOURS OF OPERATION. THIS PERSON SHOULD ENSURE THAT EMPLOYEES ARE PRACTICING GOOD HAND WASHING PROCEDURES, INCLUDING BEING KNOWLEDGEABLE ABOUT WHEN HAND WASHING SHOULD BE DONE AND HOW TO PROPERLY WASH HANDS.

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

Food and Beverage Establishment Inspection Report

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 1008221052 of 11/08/22.

Certified Food Protection Manager: Jillian A OBrien-Tadych

Certification Number: FM112035 Expires: 04/04/25

Signed: emailed to MRD
Establishment Representative

Signed: Inspector ID# 1088

Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us